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ABSTRACT

These skill standards, developed through a consortium of educational and industry partners in Illinois, serve as guides to workforce preparation program providers to define content for their programs and to employers to establish the skills and standards necessary for job acquisition and performance. The skill standards include the following components for each skill defined: performance area; performance skill; skill standard; and performance elements and assessment criteria. This publication contains skill standards for medical office personnel defined on three levels (Certified Nursing Assistant, Licensed Practical Nurse, and Registered Nurse) by increasing level of difficulty. The skill standards are grouped in the following areas: (1) safety; (2) comfort; (3) physical care; (4) bedmaking; (5) nutrition; (6) elimination; (7) vital signs; (8) body mechanics; (9) admission and discharge; (10) patient test management; (11) surgical procedures; (12) treatments; (13) dressings; (14) nursing process; (15) medications; and (16) communication. Each area contains two-nine standards. The following items are appended: glossary; lists of Illinois Occupational Skill Standards and Credentialing Council, Health and Services Subcouncil, and Nursing Cluster Standards Development Committee members; Health and Social Services; Subcouncil Nursing Services Cluster Recognition Proposal; and a list of workplace skills. (KC)

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ILLINOIS

OCCUPATIONAL SKILL STANDARDS

NURSING CLUSTER

ILLINOIS OCCUPATIONAL SKILL STANDARDS
NURSING CLUSTER

PROJECT STAFF

Health and Social Services Subcouncil Chair
Joseph A. Bonefeste, Ph.D.
Chair, Executive Director
Illinois Health Care Cost Containment Council

Health and Social Services Subcouncil Liaison
Kathryn Torricelli
Principal Consultant
Illinois State Board of Education

Product Developer for Nursing Standards
Mary Mulcahy, Ed.D.
University of Illinois at Springfield

AGENCY PARTNERS

Illinois State Board of Education
Illinois Community College Board
Illinois Board of Higher Education
Illinois Department of Commerce and Community Affairs
Illinois Department of Employment Security

ILLINOIS OCCUPATIONAL SKILL STANDARDS

NURSING CLUSTER

Endorsed for Illinois
by the
Illinois Occupational Skill Standards and
Credentialing Council

MESSAGE TO ILLINOIS CITIZENS

Dear Citizens of Illinois:

Preparing youth and adults to enter the workforce and to be able to contribute to society throughout their lives is critical to the economy of Illinois. Public and private interest in establishing national and state systems of industry-driven skill standards and credentials is growing in the United States, especially for occupations that require less than a four-year college degree. This interest stems from the understanding that the United States will increasingly compete internationally and the need to increase the skills and productivity of the front-line workforce. The major purposes of skill standards and credentialing systems are to promote education and training investment and ensure that this education and training enable students and workers to meet industry standards that are benchmarked to our major international competitors.

The Illinois Occupational Skill Standards and Credentialing Council (IOSSCC) has been working with industry subcouncils, the Illinois State Board of Education and other partnering agencies to adopt, adapt and/or develop skill standards for high-demand occupations. This document represents the work of the Health and Social Services Subcouncil and the associated standards development committee. Through this collaborative effort, skill standards products are being developed for a myriad of industries, occupational clusters and occupations. Upon completion of these products, there will be a period of feedback and comment from business, industry and labor representatives, as well as educators.

These documents will serve as guides to workforce preparation program providers to define content for their programs and to employers to establish the skills and standards necessary for job acquisition. These standards will also serve as a mechanism for communication among education, business, industry and labor.

We encourage you to review these standards and share your comments. This effort has involved a great many people from business, industry and labor. Comments regarding their usefulness in curriculum and assessment design, as well as your needs for inservice and technical assistance in their implementation, are critical to our efforts to move forward and improve the documents. A feedback instrument is included with this document.

Questions concerning this document may be directed to:

Kathryn Torricelli, Illinois State Board of Education (217/782-2826)
Carol Lanning, Illinois Community College Board (clanning@iccb.state.il.us)
Linda Lafferty, Illinois State Board of Education (llaffert@smtp.isbe.state.il.us)
Bud Johnston, Illinois Department of Commerce and Community Affairs (217/785-6210)
Dave Gallagher, Illinois Department of Commerce and Community Affairs (dgags@aol.com)

We look forward to your comments.

Sincerely,

The Members of the IOSSCC

Margaret Blackshere   Michael P. O'Neil   Gerald Schmidt
David Ammsen   Jane T. Byrne   Jim Schultz
Larry Vaughn

THE ILLINOIS PERSPECTIVE

The Illinois Occupational Skill Standards and Credentialing Council (IOSSCC) endorses occupational skill standards and credentialing systems for occupations that (a) require basic workplace skills and technical training, (b) provide a large number of jobs with either moderate or high earnings, and (c) provide career advancement opportunities to related occupations with moderate or high earnings. The nine-member Council was established by the Occupational Skill Standards Act (PA 87-1210). The council, representing business, industry and labor and working with the Illinois State Board of Education in partnership with the Illinois Community College Board, Illinois Board of Higher Education, Illinois Department of Employment Security and Illinois Department of Commerce and Community Affairs, has created a common vision for workforce development in Illinois.

Vision

It is the vision of the IOSSCC to develop a statewide system of industry-defined and recognized skill standards and credentials for all major skilled occupations providing strong employment and earnings opportunities in Illinois. Information related to occupational employment and earning opportunities is determined by the Illinois Occupational Information Coordinating Committee (IOICC) in cooperation with business and industry.

Subcouncils and Standards Development Committees

The Council developed industry subcouncils (representing all major industries in Illinois) to review, approve and promote occupational skill standards and credentialing systems. In cooperation with organizations such as the Illinois Chamber of Commerce, the Illinois AFL-CIO, the Illinois Manufacturers' Association and others, the Council established the first five subcouncils in 1995—Agriculture and Natural Resources, Manufacturing, Health and Social Services, Hospitality, and Business and Administrative/Information Services.

The remaining subcouncils include Applied Science and Engineering Services; Legal and Protective Services; Transportation, Distribution and Logistics; Educational Services; Financial Services; Marketing and Retail Trade; Communications; Construction; and Energy and Utilities.

The Standards Development Committees, composed of business, labor and education representatives, are experts in the related occupational cluster and work with the product developer to

- develop or validate occupational skill standards,
- identify related academic skills,
- develop or review assessment or credentialing approaches, and
- recommend endorsement of the standards and credentialing system to the industry subcouncil.

Expected Benefits for Employers, Educators, Students and Workers

Occupational skill standards and credentialing systems are being developed and promoted by the IOSSCC to improve Illinois' competitiveness. Such standards and credentialing systems provide a common language for employers, workers, students and education and training providers to communicate skill requirements and quality expectations for all major industry and occupational areas.

For Employers, skill standards will

- Improve employee recruitment and retention by more clearly identifying skill requirements,
- Encourage improved responsiveness and performance of education and training providers,
- Enlarge the pool of skilled workers,
- Focus attention on the importance of training investment.

For Education and Training Providers, skill standards will

- Provide information on all major industries and occupations,
- Contribute to program and curriculum development,
- Strengthen relationships between educators and training providers,
- Improve career planning.

For Students and Workers, skill standards will

- Foster better decision making concerning careers and the training necessary to acquire well-paying jobs,
- Allow more effective communication with employers about what they know and can do,
- Allow more effective work with employers in career development and skill upgrading.

IOSSCC Requirements for Occupational Skill Standards

Any occupational skill standards and credentialing system seeking IOSSCC endorsement must

- represent an occupation or occupational cluster which meets the criteria for IOSSCC endorsement;
- address both content and performance standards for critical work functions and activities for an occupation or occupational area;
- ensure formal validation and endorsement by a representative group of employers and workers within an industry;
- provide for review, modification and revalidation by an industry group a minimum of once every five years;
- award credentials based on assessment approaches that are supported and endorsed by the industry and consistent with nationally recognized guidelines for validity and reliability;
- provide widespread access and information to the general public in Illinois;
- include marketing and promotion by the industry in cooperation with the partner state agencies.

Definitions and Endorsement Criteria

The definitions and endorsement criteria are designed to promote the integration of existing and future industry-recognized standards, as well as the integration of the Illinois academic and occupational skill standards. Because all skill standards must address the critical work functions and activities for an occupation or industry/occupational area, the Council further defined three major components:

- ***Conditions of Performance:*** The information, tools, equipment and other resources provided to a person for a work performance.
- ***Work to be Performed:*** A description of the work to be performed by a person.
- ***Performance Criteria:*** The criteria used to determine the required level of performance. These criteria could include product characteristics (e.g., accuracy levels, appearance), process or procedural requirements (e.g., safety, standard professional procedures) and time and resource requirements. The IOSSCC also requires performance criteria to be further specified by detailed individual performance elements and assessment criteria.

The IOSSCC is currently working with the Illinois State Board of Education and other state agencies to integrate the occupational standards with the Illinois Learning Standards which describe what students should know and be able to do as a result of their education. The Council is also working to integrate workplace skills—problem solving, critical thinking, teamwork, etc.—with both the Learning Standards and the Occupational Skill Standards.

The Illinois Model

Illinois Occupational Skill Standards describe what people should know and be able to do and how well these skills and knowledge will be demonstrated in an occupational setting. They focus on the most critical work performances for an occupation or occupational area. As seen in the following model, Illinois Occupational Skill Standards contain at least these areas:

- Performance Area
- Performance Skill
- Skill Standard
- Performance Elements and Assessment Criteria

The Assessment and Credentialing Approach section may also be included at the direction of the individual standards development committee.

Illinois Occupational Skill Standards also carry a coding at the top of each page identifying the state, fiscal year in which standards were endorsed, subcouncil abbreviation, cluster abbreviation and standard number. For example, the twenty-fifth skill standard in the Nursing Cluster, which has been developed by the Health and Social Services Subcouncil, would carry the following coding: IL.98.HLT/SOC.NU.25

A model for Illinois Occupational Skill Standards showing the placement of the coding and providing a description of each area within a standard is contained on the following page.

SUMMARY OF WORK TO BE PERFORMED. SUMMARY IS BRIEF AND BEGINS WITH AN ACTION VERB.

IL. FY. SUBCOUNCIL. CLUSTER. STANDARD NO.

Performance Area

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Includes all information, tools, equipment and other resources provided to the learner for performing the work.

WORK TO BE PERFORMED

Provides an overview of the performance with the major elements or steps being described under Performance Elements and Assessment Criteria.

PERFORMANCE CRITERIA

Includes product characteristics (e.g., accuracy levels, appearance) and/or process or procedure requirements (e.g., safety requirements). Time limits, rates and/or speeds are specified in the Performance Criteria.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

Statement of the major elements, components or steps of the overall performance and the assessment criteria for determining successful performance. Includes all major tasks, the knowledge to be demonstrated and specific assessment criteria.

ASSESSMENT AND CREDENTIALING APPROACH

Optional statement of suggested assessment approaches for the performance which also refers to existing assessment and credentialing systems.

DEVELOPMENTAL PROCESS

After studying the current labor market information, the Health and Social Services Subcouncil recommended the nursing cluster to be the first occupational area for which performance skill standards would be developed. This cluster meets the criteria established by the Council for performance skill standard development, education and training requirements, employment opportunities, earnings potential and/or career opportunities. The careers identified in the nursing cluster begin with the Certified Nurse Assistant (CNA) through the Licensed Practical (LPN) and Registered Nurse (RN) occupations. A product developer knowledgeable with the nursing cluster began the process of performance skill identification. Given the range of skill within the three occupations, the initial charge for the product developer was to prepare an organizational framework that would address the major skills expected in the workplace. The framework sets the parameter for addressing the clients' activities of daily living needs and the skill level necessary to meet these needs.

Job descriptions from clinical agencies that cross the health care spectrum and competencies addressed in related educational programs were solicited and received. National Health & Social Services skill standards for health care workers and those of Illinois outlined in the licensing guidelines were consulted. Illinois task lists developed to form the basis of instructional content for secondary, postsecondary and adult occupational training programs were referenced. Common and accepted references provided reinforcement for the direction given in the framework. Those references included current texts used by educational institutions, the Illinois Nurse Practice Act, the American Nurses Association Code of Ethics, a statement of client rights and the Illinois Nursing Articulation Model which was developed under the authority of the Illinois Board of Higher Education, the Illinois Community College Board and the Illinois State Board of Education.

A standards development committee composed of workers at all levels within the cluster was convened. The framework and initial outline of performance skills were presented to the standards development committee for review, adjustment and/or validation. During a two-day meeting, the framework was accepted and the outline of skills finalized. Work then started on the development of the skill standards statements and the elements/assessment criteria in accordance with the direction established by the Illinois Occupational Skill Standards and Credentialing Council. The product developer submitted the draft performance skill standards to the Standards Development Committee for review and revision. The Standards Development Committee met once again to review the skill standards statements and make recommendations focused on consistency in terminology.

Performance elements and assessment criteria were developed using standard reference texts. The initial and concluding parts of the format establish a standard of personal conduct and provide a reminder of expected workplace behaviors. The central section varies in length and outlines the specific criteria expected for evaluation in the learning environment and for entry into the workplace. Caregivers will view the skill standards in relation to the facility's philosophy, always maintaining an awareness of safety, client rights and infection control. The criteria are behavioral statements of skill standards. As such, they serve as an evaluation tool and workplace guide but are not a prescription for curriculum.

A complete set of skill standards statements was provided to the Subcouncil. At the recommendation of the Subcouncil, copies of the performance skill standards were distributed for further review by a selected health care community. The Subcouncil also reviewed the materials in depth. Comments submitted by members of the Subcouncil and those requested from outside reviewers have been integrated into the final product. A statement of assumptions accompanies this document to provide context for the standards document.

ASSUMPTIONS FOR NURSING STANDARDS

Skill standards statements assume:

1. Workplace skills (employability skills) are expected of all learners. Socialization skills needed for work are related to lifelong career experience and are not solely a part of the initial schooling process. These are not included with this set of statements.
2. Specific policies and procedures of the worksite will be made known to the learner and will be followed.
3. Time elements outlined for the skill standards result from the experience and consideration of the panel of experts who made up the Standards Development Committee.
4. Skills will progress from simple to complex. Once a skill has been successfully performed, it will be incorporated into more complex skills.
5. Skill standards describe the skill only and do not detail the background knowledge or theory related to the particular skill base. Although the skill standard enumerates steps to successful demonstration, rote approaches to the outcomes are not prescribed.
6. All skills are to be accompanied by a "room/environment" check that leaves the site neat and clean, a safe place in which to live and work. This corresponds with a view of the client as a resident and guest of the health care facility.
7. Testing conditions will be conducive to meeting the standard of performance. Standard equipment will include bed, bedside table, overhead table, chair, privacy screen or curtain, signal light or call bell, bathroom, closet or drawer space, client identification system (bracelet, name over bed, picture of client).
8. The skill standards intended to reflect competencies at entry level of the identified occupations are to be tested with clients in stable, clinical conditions in structured, supervised settings
9. Universal precautions are expected to be used for all interactions with clients.
10. Client rights will be learned as part of the schooling process and will be respected and expected as part of employment.
11. The American Nurses Association Code for Nurses and the Illinois Nursing Act give direction to the ethical and legal dimensions of practice.

TABLE OF CONTENTS

PERFORMANCE SKILL LEVELS

	CNA	LPN	RN
SAFETY			
Wash Hands (Medical Asepsis)	●	●	●
Use Disposable Gloves	●	●	●
Use Universal Precautions	●	●	●
Assist Client Who Is Using a Cane or Walker to Ambulate	●	●	●
Apply and Monitor Protective Devices	●	●	●
COMFORT			
Assist with Oral Hygiene	●	●	●
Give a Back Rub	●	●	●
Shave a Client	●	●	●
Assist with Daily Hair Care	●	●	●
Cleanse and Care for Dentures	●	●	●
Assist Client with Early Morning Care	●	●	●
Assist Client with Bedtime Care	●	●	●
PHYSICAL CARE			
Assist with Tub Bath or Shower	●	●	●
Give a Partial and/or Complete Bed Bath	●	●	●
Give Female Perineal Care	●	●	●
Give Male Perineal Care	●	●	●
Perform Nail Care for Hands and Feet	●	●	●
BEDMAKING			
Prepare the Open/Closed Bed	●	●	●
Make an Occupied Bed	●	●	●
NUTRITION			
Provide Oral Fluids and Foods	●	●	●
Perform Intermittent and Continuous Gastrostomy/Nasogastric Feedings		●	●
Maintain Patency of a Gastrostomy/Nasogastric Tube		●	●
Care for and Monitor Peripheral Intravenous Therapy Site		●	●

ELIMINATION

	CNA	LPN	RN
Assist with Use of the Bedpan	●	●	●
Assist with Use of the Bedside Commode	●	●	●
Assist with Use of the Urinal	●	●	●
Insert and Maintain Patency of an Indwelling Catheter		●	●
Assist with Care of Indwelling Catheter	●	●	●
Measure Contents of a Urinary Drainage Unit and Empty	●	●	●
Give a Tap Water Enema	●	●	●
Provide Ostomy Care	●	●	●

VITAL SIGNS

Measure and Record Oral Temperature, Radial Pulse and Respirations	●	●	●
Count, Record and Report Apical Pulse	●	●	●
Measure and Record Axillary Temperature	●	●	●
Measure and Record Rectal Temperature	●	●	●
Measure and Record the Blood Pressure	●	●	●
Measure and Record Height and Weight	●	●	●
Measure and Record Fluid Intake and Output	●	●	●

BODY MECHANICS

Assist the Client to Move between Chair, Wheelchair, Bed and/or Bathroom Stool	●	●	●
Use a Transfer (Gait) Belt to Assist with Movement and Ambulation	●	●	●
Provide Assistance for the Falling Client	●	●	●
Reposition the Client in Bed	●	●	●
Perform Passive and Active Range of Motion Exercises to Upper and Lower Extremities	●	●	●
Use a Wheelchair to Transport a Client	●	●	●
Use a Stretcher to Transport a Client	●	●	●

ADMISSION AND DISCHARGE

Admit the Client to the Unit, Service and/or Facility	●	●	●
Transfer the Client between Units within the Facility	●	●	●
Collect, Report and Record Client Data on an Ongoing Basis	●	●	●
Discharge the Client from the Facility	●	●	●

PERFORMANCE SKILL LEVELS

TEST MANAGEMENT

	CNA	LPN	RN
Collect a Random Urine Specimen for Routine Urinalysis	●	●	●
Collect Urine for Culture and Sensitivity	●	●	●
Collect a Timed (24, 12, 6, 4, 2 Hour) Urine Specimen	●	●	●
Collect a Fecal (Stool) Specimen	●	●	●
Collect a Sputum Specimen	●	●	●
Collect a Wound Drainage Specimen		●	●
Test Blood Sugar (Finger-Stick Method)	●	●	●

SURGICAL PROCEDURES

Prepare Client for Surgery			●
Provide Post-Operative Care		●	●

TREATMENTS

Administer Oxygen by Mask and by Cannula		●	●
Assist Client to Turn, Cough and Deep Breathe		●	●
Perform Oral Suctioning		●	●
Assist with Use of Incentive Spirometry		●	●
Provide Tracheostomy Care		●	●
Measure Oxygen Saturation with Pulse Oximeter		●	●

DRESSINGS

Apply Warm/Cold Applications	●	●	●
Change Nonsterile Dressings		●	●
Maintain Function of Self-Contained Wound Drainage Apparatus		●	●
Change Sterile Dressing		●	●
Care for an Intravenous Therapy Site			●
Irrigate Wound		●	●
Remove Sutures		●	●

NURSING PROCESS

Demonstrate Problem Solving		●	●
Demonstrate Critical Analysis			●

PERFORMANCE SKILL LEVELS

MEDICATIONS

	CNA	LPN	RN
Administer Medications		●	●
Administer Oral Medications		●	●
Administer Intramuscular Injection		●	●
Administer Subcutaneous Injection		●	●
Administer Medication by Suppository		●	●

COMMUNICATION

	CNA	LPN	RN
Use Principles of Communication	●	●	●
Send and Receive Information	●	●	●
Communicate and Collaborate within Health Care Team	●	●	●
Establish a Plan of Care			●
Assess Client's and Significant Others' Need for Information			●
Instruct, Evaluate and Reinforce Health Maintenance Techiques and Resources for Client and Significant Others			●

WASH HANDS (MEDICAL ASEPSIS)

Maintain safety and security of client/family/self/ others by observing safety precautions and promoting a sense of security and well-being.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

a cleansing agent	paper towels
a sink with running water	waste container

WORK TO BE PERFORMED

Wash hands, wrists (forearms) and fingernails in an aseptic manner.

PERFORMANCE CRITERIA

The entire skill will be done in 2-3 minutes with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Clear hands and forearms to wrist level.
2. Stand so that clothing does not touch the sink.
3. Turn on water. Adjust temperature to warm and leave the water running. Have paper towel or drying towel available.
4. Wet hands thoroughly with water, holding hands downward, lower than the level of the elbows throughout the procedure.
5. Apply soap or cleansing agent to hands using available products.
6. Wash hands using friction for sixty seconds:
   a. Wash palms and back of hands using circular motions and friction for 10-15 seconds.
   b. Rub the fingernails against the opposite hand to force soap under the nails for cleaning.
   c. Wash between fingers by interlacing fingers and using friction for 10-15 seconds. If wedding band is in place, slide it up and wash beneath it.
7. Wash wrists and forearms using friction for 15 seconds.
8. Rinse hands and forearms well under running water with the fingertips downward.
9. Dry hands and forearms thoroughly with dry paper towel, from the fingertips upward. Do not contaminate the clean surfaces. Use a separate paper towel, or more as necessary, for each hand and forearm. Dispose of used paper towels in the waste container.
10. Turn off water with clean, dry paper towel held between the hand and faucet, without touching the sink. Dispose of the towel without touching the waste container.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of hand washing technique observing medical asepsis.

Performance of procedure under supervision.

USE DISPOSABLE GLOVES

Maintain safety and security of client/family/self/ others by observing safety precautions and promoting a sense of security and well-being.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following materials and equipment:

Non-sterile, disposable gloves

Note: The use of non-sterile gloves will provide protection for the learner, the client and other personnel.

WORK TO BE PERFORMED

The learner will use non-sterile gloves as a necessary precaution in care according to approved universal precautions.

PERFORMANCE CRITERIA

The standard for use of non-sterile gloves is determined by universal precautions standards and the appropriate facility policy. Time element is not applicable.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Determine that use of non-sterile gloves is required as a protective safety measure.
2. Remove gloves by grasping the outside of one glove near the cuff, with the thumb and forefinger of the other hand. Pull it off, turning it inside out while pulling.
3. Hook the bare thumb inside the other glove and pull it off, turning it inside out. The two gloves will be rolled together, with the side that was nearest the learner's hand on the outside.
4. Dispose of the soiled gloves according to facility policy.
5. Wash and dry hands thoroughly.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and proper use of disposable gloves.

Performance of procedure for selected client.

USE UNIVERSAL PRECAUTIONS

Maintain safety and security of client/family/self/ others by observing safety precautions and promoting a sense of security and well-being.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

disposable gloves
masks and protective eyewear

Note: *Knowing and applying facility policy in relation to the use of universal precautions provides protection for the learner, the client and other personnel.*

WORK TO BE PERFORMED

Universal precautions will be demonstrated in all contact with client and throughout daily work requirements.

PERFORMANCE CRITERIA

Time element is not applicable. The standard for use of universal precautions will determine the appropriate time for use.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Wash hands immediately if they are contaminated with blood or body fluids. Also wash hands on entering the room, immediately after gloves are removed, after client contact and/or when leaving the room.
2. Masks and protective eyewear are worn if the procedure could cause droplets of blood or body fluids. Examples include brushing teeth, flossing teeth, caring for persons with frequent, productive coughs. Masks and protective eyewear prevent exposure to the mucous membranes of the mouth, eyes and nose.
3. Gowns are worn if soiling of clothing with blood or body fluids is likely.
4. Gloves are worn when touching the client's non-intact skin, body fluids, mucous membranes, body substances or when performing venipuncture. Gloves are changed for each client contact.
5. Use care to avoid cuts and nicks when using sharps such as razor blades.
6. The learner should avoid client contact if he/she has open skin areas.
7. Follow specific facility guidelines for handling linens, waste containers and broken glassware and decontamination of work surfaces following blood spills.
8. Follow additional and specific guidelines for handling needles and sharps and for specimen collection.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of applying universal precautions.

Performance of procedure for selected client.

ASSIST CLIENT WHO IS USING A CANE OR WALKER TO AMBULATE

Maintain safety and security of client/family/self/ others by observing safety precautions and promoting a sense of security and well-being.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to ambulate and given the following equipment and materials:

cane	pen
walker	paper
transfer belt	

WORK TO BE PERFORMED

Assist the client to ambulate safely maintaining principles of safety and body mechanics.

The client will demonstrate ability using a cane or walker with no untoward safety incidents. Note any unusual occurrence during ambulation.

PERFORMANCE CRITERIA

Providing assistance for the client who is ambulating with a cane or walker requires from 10-15 minutes. Assessing client needs will alter the standard time expected for this level of assistance.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (cane, walker and transfer belt), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet. Address the person by name or use facility instructions to determine identity.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or care giver.
3. Wash hands.
4. Check walker or cane for worn areas or loose parts. Be sure that rubber tips and rubber hand grips have adequate tread and are not cracked and worn. Place the cane or walker close by.
5. When client's hand(s) are in place on the cane or walker, the elbow should form a 30° angle.
6. Apply the transfer belt if necessary.
7. Hand the client the cane or place the walker in front of the client within easy reach.
8. Place the cane on the strong side. The client should advance the cane 10-18 inches followed by weaker leg and then strong leg.
9. For using a walker, have client advance the walker about 10-18 inches. Client then moves weaker leg forward into the walker followed by the stronger leg.
10. If client has a transfer belt on, stand on the client's weaker side and slightly in back with hands in the belt.

11. After ambulation, the client is returned to bed or chair. The client should walk within a step of the bed or chair. Place the cane or walker to the side and assist the client to turn around. When the client feels the bed or chair touching the back of legs, the client should reach for the arms of the chair or the mattress and lower self into the chair or bed. Make sure chair is anchored/immovable.
12. Remove any materials used in assisting with ambulation, cleansing the materials as necessary prior to storage.
13. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy and wash hands.
14. Invite visitors to return to bedside.
15. Report observations to supervising, licensed personnel to include observations about condition of client, tolerance of the exercise and degree of strength during the exercise.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of use of cane or walker to ambulate.

Performance of procedure for selected client.

APPLY AND MONITOR PROTECTIVE DEVICES

Maintain safety and security of client/family/self/ others by observing safety precautions and promoting a sense of security and well-being.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with impaired level of awareness or with a need to limit movement, in consultation with the supervising licensed personnel, and given the following equipment and materials:

paper	vest restraint
pen	belt or body restraint
order for restraints	wrist or ankle restraint
privacy of the client	hand restraint

WORK TO BE PERFORMED

Apply protective devices, as ordered by physician, in a safe manner.

PERFORMANCE CRITERIA

The following client safety issues will be observed:

- Application of the restraint will not interfere with circulation.
- Vest, belt, wrist and ankle devices are secured to movable parts of bed frame.
- Fingers can be flexed inside mitts.
- Gown and vest are free of wrinkles.
- Restraint allows limited movement of the applicable body part.
- Restraints do not interfere with treatment, health problems or circulation.

The client will be comfortable and in a safe environment. Questions from client, family and significant others will be addressed in a courteous and factual manner.

Observation and restraint criteria will be noted.

Applying a restraint to a client for the purpose of maintaining safe conditions requires a varying length of time dependent upon need and type of restraint. Assessing client needs will alter the standard time expected for this level of assistance.

Skill will be performed with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Prior to application of a restraint, attempt to use other measures to maintain safety of the client and address the need, including reorientation to circumstances and determining whether family or significant other persons in attendance could assist with care.
2. Document, through description, the client's behaviors which are detrimental to safety. Indicate why a restraint should be considered.
3. Obtain/verify an order for restraints from supervising licensed personnel.
4. Gather equipment to be used, determined by the reason for application of the restraint and from order of appropriate supervising licensed personnel. Use the least restrictive device possible.

5. Upon entering the client's room, verify the client's name and explain the procedure to the client and to those present at the bedside.
6. Wash hands. Provide for privacy of the client.
7. For application of vest restraint:
   a. Place vest over client's clothing.
   b. Ensure that clothing and vest are not wrinkled.
   c. Secure straps to movable portion of bed frame or to the back frame of chair, using half-bow knot.
   d. Remove and evaluate need at least every two hours.
8. For application of belt or body restraint:
   a. Fasten the top or smaller belt around the client's waist.
   b. Fasten the lower belt to the movable part of the bed frame. Restraints are not fastened to bed rails.
   c. Remove and evaluate need at least every two hours.
9. For application of wrist or ankle restraint:
   a. Apply pad around wrist or ankle.
   b. Pull strap through slit.
   c. Attach strap to movable portion of bed frame using half-bow knot.
   d. Check every 15 minutes.
10. For application of hand restraint:
    a. Apply mitt to hand to be restrained making sure fingers are flexed and are not caught under hand.
    b. Wash and exercise hand at least every 8-12 hours if mitt is worn for more than one day.
11. Check client frequently for safety, comfort and circulation, making adjustments in restraint as necessary to maintain safety and effectiveness.
12. Remove for at least ten minutes and readjust the restraint at least every two hours or as frequently as needed to maintain safe conditions.
13. Leave signal bell within reach of client.
14. Document the type of restraint used, the time of application and removal, intervening care provided, client behavior prior to application of restraint and following application, explanation provided to client and to support persons and notice to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles for applying and monitoring protective devices.

Performance of procedure for selected client.

ASSIST WITH ORAL HYGIENE

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to independently carry out routine oral hygiene and given the following equipment and materials:

paper	drinking straw
pen	face towel
toothbrush	water glass with cool water
toothpaste or powder	disposable gloves
mouthwash solution in cup	paper bag
emesis basin	appropriate screening
bath towel	lip balm

WORK TO BE PERFORMED

Assist with oral hygiene at least three times per day: with morning care, following noon meal and when preparing for sleep.

PERFORMANCE CRITERIA

Client will express comfort and feeling of freshness. No halitosis or extraneous particles will be detected.

Notation and report will be made of condition of teeth, mouth and tongue.

Skill will be performed with 100% accuracy.

Assistance with care requires 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (toothbrush, toothpaste or powder, mouthwash solution in cup, emesis basin, bath towel, drinking straw, face towel, water glass with cool water, disposable gloves and paper bag). Go to client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide privacy of the client. Provide appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment at the bedside for ease of use and ready access, turning client to side if necessary for safety and if not contraindicated.
5. Position client in bed to accommodate care, raising head of bed if feasible and not contraindicated, turning client to side if necessary for safety.
6. Place bath towel over client's gown and bed covers.
7. Moisten toothbrush and apply toothpaste or powder.
8. Put on disposable gloves.
9. Brush teeth using the following process:
   - Turn toothbrush with bristles toward teeth.
   - Brush all tooth surfaces with an up-and-down motion.

10. Give client water in cup to rinse mouth. Use straw, if necessary. Turn the client's head to one side with emesis basin near chin for return of fluid.
11. Repeat steps 9 and 10 until all teeth have been brushed and mouth has been rinsed. Offer mouthwash, diluted if necessary, as client desires.
12. Assist client to wipe mouth and chin as necessary to maintain cleanliness and tidiness as much as possible. Apply lip balm as permitted and acceptable to client.
13. Remove materials used in assisting with oral hygiene, rinsing the toothbrush with water, storing materials in clean fashion. Remove and dispose of gloves according to facility policy.
14. Leave client in a comfortable, safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
15. Invite visitors to return to bedside.
16. Report observations to supervising, licensed personnel including condition of lips (dry, cracked, swollen or blistered), the mouth, tongue (redness, swelling, irritation, sores or white patches) and gums (bleeding, swelling or excessive redness).

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in assisting with oral hygiene.

Performance of procedure for selected client.

GIVE A BACK RUB

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

disposable gloves	lotion
bath towel	appropriate screening

WORK TO BE PERFORMED

Give a back rub to stimulate circulation, help prevent skin breakdown and assist in soothing and refreshing the condition of the client.

PERFORMANCE CRITERIA

A back rub is routinely provided with a bath, when changing the position of a helpless client, at time of sleep and when it will comfort the client. Client will express comfort and feeling of relaxation. Notation will be made of reddened areas that do not whiten to pressure, any braised or bruised areas of skin and the condition of skin over bony prominence.

Skill will be performed with 100% accuracy.

The back rub requires 3-5 minutes for completion.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble the equipment (disposable gloves if condition warrants, bath towel and lotion), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or by using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Raise far side rails; raise the bed to a height that is comfortable for the learner.
5. Turn the client to a side-lying position with back to the learner. Expose the back while maintaining privacy for the rest of the body. Place a bath towel below the back to prevent soiling of bed clothes.
6. Cleanse the back as necessary when back rub is given at times other than the routine bath.
7. Pour a small amount of lotion in one palm; rub palms together to warm the lotion.
8. Use long, soothing strokes beginning at the base of the spine; rub up the center of the back, out across the shoulders and down the sides of the back and buttocks. Repeat this type of stroking four times, using a circular motion on the downstroke. Repeat steps, but on downward motion; use small circular motion with the palm of the hand. Finish with a repeat of the long soothing stroke motion.

9. Rub the lotion into the skin; dry the skin of the back.
10. Remove and dispose of gloves if used for back rub according to facility procedure.
11. Straighten and tighten the bed sheets, especially the drawsheet.
12. Change the client's nightgown and bedclothes as necessary.
13. Remove the materials used in giving the back rub.
14. Restore client to comfortable, safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
15. Report observations to supervising, licensed personnel to include observations about general client condition, any expressed concerns, condition of the skin of the back and any new broken areas or areas of redness not responding to massage.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of giving a back rub, reasons for a back rub and general precautions to be used in giving a back rub.

Performance of the skill with a selected client.

SHAVE A CLIENT

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to independently shave self and given the following equipment and materials:

paper	basin of water
pen	face towel
disposable gloves	mirror
electric shaver or safety razor	after-shave lotion or powder
shaving lather	warm, moist cloth
electric preshave lotion	appropriate screening

WORK TO BE PERFORMED

Assist with shaving as needed for neatness of appearance.

PERFORMANCE CRITERIA

Client will express comfort and feeling of freshness and have a neat appearance, with no abrasions resulting from the process.

Notation will be made of skin condition of face and neck.

Skill will be performed with 100% accuracy.

Assisting the client to shave will require 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (disposable gloves, electric shaver or safety razor, shaving lather or an electric preshave lotion, basin of water, face towel, mirror and after-shave lotion or powder), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment on the overbed table for ease of use and ready access. Raise far side rail. Position bed at level of comfort for the learner and for client.
5. Put on disposable gloves.
6. Place face towel across client's chest.
7. Moisten face and apply lather. Soften beard with a warm, moist cloth.

8. Starting in front of the ear:
   a. Hold skin taut.
   b. Bring razor down over cheek toward chin.
   c. Repeat until lather on cheek is removed and area has been shaved.
   d. Repeat on other cheek.
   e. Shave chin carefully; having the client tense the area helps smooth out the tissue.
   f. Raise chin and shave neck area on each side, bringing razor up toward chin.
   g. Use firm, short strokes.
   h. Rinse razor frequently.
9. Lather neck area and stroke up toward the chin in a similar manner.
10. Wash face and neck. Dry thoroughly.
11. Apply after shave lotion or powder, if desired.
12. Remove materials used in shaving, rinsing them as needed and storing materials in a clean fashion. Remove and dispose of gloves according to facility policy.
13. Restore client to comfortable, safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
14. Invite visitors to return to bedside.
15. Report completion of task; record date, time, face shaved and client reaction.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for shaving a client.

Performance of procedure for selected client.

ASSIST WITH DAILY HAIR CARE

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to independently care for his/her hair and given the following equipment and materials:

paper	comb
pen	brush
towel	appropriate screening

WORK TO BE PERFORMED

Assist with or provide hair care as dictated by client's condition.

PERFORMANCE CRITERIA

Hair care is provided as part of daily care or when necessary for maintenance of appearance and comfort. Hair care should serve to stimulate circulation to the scalp, refresh the client and maintain cleanliness and neatness.

Hair will be neat and clean.

Amount of time needed depends on length and condition of client's hair and usually ranges from 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (towel and comb and brush), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment on the overbed table for ease of use and ready access. Raise far side rail. Position bed at level of comfort for the learner and for client.
5. Cover the pillow with a towel.
6. Part or section hair and comb with one hand between scalp and end of hair.
7. Brush carefully and thoroughly.
8. Position client so hair on the back of the head may be combed and brushed. If hair is tangled, untangle hair; working section by section. Begin near the ends and work toward the scalp.
9. Complete brushing and arrange attractively. Braid long hair to prevent repeated tangling if client agrees.
10. Remove materials used to assist with hair care, rinsing them as needed and storing materials in a clean fashion. Remove and dispose of gloves according to facility policy.

11. Restore client to comfortable, safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
12. Invite visitors to return to bedside.
13. Report completion of task; record date, time, hair care provided, condition of hair and client reaction.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in assisting with hair care.

Performance of procedure for selected client.

CLEANSE AND CARE FOR DENTURES

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to independently carry out routine denture care and given the following equipment and materials:

paper	tooth cleanser
pen	gauze squares
disposable gloves	denture cup
tissues	appropriate screening
emesis basin	lip balm
tooth/denture brush	

WORK TO BE PERFORMED

Cleanse and care for the client's dentures.

Client will express comfort and feeling of freshness when clean dentures are inserted. No halitosis will be noted. Notation will be made of the condition of the tongue and any lesions in the mouth or other untoward signs such as abrasions or bleeding.

Denture cup will be clean and ready for storage of dentures.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Cleaning the dentures will require 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (disposable gloves, tissues, emesis basin, tooth/denture brush, tooth cleanser, gauze squares and denture cup), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment on the overbed table for ease of use and ready access. Raise far side rail. Position bed at level of comfort for the learner and for client.
5. Allow the client to clean dentures if able. If the client is unable to independently clean dentures:
   a. Put on gloves.
   b. Give tissue to client.
   c Ask client to remove dentures; assist as necessary.

6. Remove dentures if client is unable to do so:
   a Ask client to open mouth.
   b. Firmly grasp upper dentures; gently ease down and forward and remove from mouth.
   c. Firmly grasp lower dentures; gently ease up and forward and remove from mouth.
7. Place dentures in cup or basin padded with gauze squares; take to bathroom or appropriate area.
8. Soak dentures in cup or denture cup over a sink padded with wash cloths in case dentures are dropped.
9. Cleanse with tooth/denture brush and tooth paste or powder. Hold the dentures firmly as they are cleansed; rinse as necessary and when brushing is completed.
10. Rinse container used for denture storage. Place dentures in storage cup.
11. Assist client to rinse mouth with water and/or mouthwash. Using a soft brush, cleanse the mouth and tongue, observing the condition of the mouth, gums and lips.
12. Using gauze or clean wash cloth to handle the dentures, give to client to insert or insert them if necessary. Grasp dentures in the middle, insert one end at a time into client's mouth, press them gently, but firmly, in place.
13. Assist client to wipe mouth and chin as necessary to maintain cleanliness and tidiness. Apply lip balm as permitted and acceptable to client.
14. Remove materials used to assist with denture care, rinsing them as needed and storing materials in a clean fashion. Remove and dispose of gloves according to facility policy.
15. Restore client to comfortable, safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
16. Invite visitors to return to bedside.
17. Report completion of task; record date, time, denture care provided, condition of mouth and client reaction.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in caring for dentures.

Performance of procedure for selected client.

ASSIST CLIENT WITH EARLY MORNING CARE

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is alert but unable to independently perform early morning care and given the following equipment and materials:

- paper
- pen
- toilet articles
- lotion
- wash water
- blood pressure cuff (sphygmomanometer)
- stethoscope
- thermometer
- bedpan/urinal
- appropriate screening
- watch with second hand

WORK TO BE PERFORMED

Assist with early morning care.

PERFORMANCE CRITERIA

Client will express satisfaction with the degree of comfort provided. The client will be clean and comfortable, and the environment will be safe.

Skill will be performed with 100% accuracy.

Performance of early morning care will require 10-15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (wash water, toilet articles, lotion, equipment to measure vital signs and bedpan/urinal), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet. If the client is still sleeping, awaken him/her by gently placing a hand on the client's arm and using the client's name.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Offer the bedpan or urinal or assist in use of bathroom facilities. Collect any specimens as directed by supervising licensed personnel.
5. Take routine vital signs (temperature, pulse, respiration and blood pressure) if required by facility policy and procedure.
6. Arrange equipment on the overbed table for ease of use and ready access. Ensure side rails are appropriately fixed for client safety. Position bed at level of comfort for learner and for client. Assist client with care as necessary.
7. Ensure that client is able to cleanse face and care for mouth and hair providing assistance as needed.
8. Give back rub as required for client comfort and preventive measures.

9. Ensure that bed sheets are tight. Change bed linens and client's gown as necessary. (In long-term care facilities, the resident/client should be dressed in their own clothing and footwear which is neat, clean and in good repair.)
10. Clear the overbed table and adjust the backrest of the bed, if permitted, so client is ready to eat breakfast.
11. Remove materials used to assist with early morning care, rinsing them as needed and storing materials in a clean fashion. Remove and dispose of gloves according to facility policy.
12. Restore client to comfortable, safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
13. Report completion of task; record date, time, morning care provided, assessment findings, general condition of client and client reaction.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in assisting client with early morning care.

Performance of procedure for selected client.

ASSIST CLIENT WITH BEDTIME CARE

Perform nursing care to meet basic daily physical care and comfort needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to independently prepare for sleep and given the following equipment and materials:

- paper
- pen
- nourishment as permitted
- wash water
- toilet articles
- lotion
- bedpan/urinal
- appropriate screening
- disposable gloves

WORK TO BE PERFORMED

Assist the client to prepare for sleep.

PERFORMANCE CRITERIA

Client will express comfort and readiness for relaxation, rest and sleep. The environment will be made as conducive for rest as possible.

Skill will be performed with 100% accuracy.

Assistance with bedtime care requires 10-15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (nourishment as permitted, wash water, toilet articles, lotion and bedpan/urinal), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Offer nourishment as permitted and in accord with dietary restrictions.
5. Offer bedpan or urinal or assist to bathroom facilities as necessary. Use disposable gloves as needed.
6. Provide wash water and toilet articles. Assist to cleanse face and hands and to complete tooth and hair care as necessary.
7. Give back rub with special attention to pressure points. Note condition of skin.
8. Tighten lower sheet and drawsheet as necessary. Change any soiled linens. Straighten top bedclothes.
9. Place overbed table at foot of bed or at side of bed. Put bed in lowest horizontal position possible. Follow facility policy regarding bed rail position.
10. Remove materials used to assist with bedtime care, rinsing them as needed and storing materials in a clean fashion. Remove and dispose of gloves according to facility policy.

11. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
12. Report completion of task; record date, time, type and degree of bedtime care provided and general condition of client.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in assisting client with bedtime care.

Performance of procedure for selected client.

ASSIST WITH TUB BATH OR SHOWER

Perform nursing care to meet basic physical care needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is alert but unable to routinely and independently perform basic daily physical care needs and given the following equipment and materials:

pen	chair or stool
paper	tub or shower chair
soap	client apparel
washcloth	bath mat
bath towels	appropriate screening
bath blanket	disposable gloves
lotion	deodorant

WORK TO BE PERFORMED

Assist with a tub bath or shower.

PERFORMANCE CRITERIA

Client is odor-free, clean and dry and will express sense of comfort and feeling of cleanliness.

Observations specified by the supervising licensed personnel and any unanticipated findings will be noted.

Skill will be performed with 100% accuracy.

Assistance with the tub bath or shower requires 20-30 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (soap, washcloth, bath towels, bath blanket, lotion, chair or stool, tub or shower chair as needed, client apparel and bath mat), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using the facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Take the supplies to the bathroom. Prepare the bathroom for the client, making sure the tub or shower stall is clean.
5. Fill the tub half full with water or turn on the flow of water from the shower. A water temperature of 95-105° will be comfortably warm to the inside of the wrist of the learner.
6. Assist the client to put on robe and slippers and accompany him/her to the bathroom.
7. Help the client remove clothing as necessary. Provide privacy as possible with bath towel.

8. If necessary, place tub or shower chair or stool in place for client use. Assist the client into the tub or shower. Use gloves if appropriate.
9. Wash the client's back. Assist to cleanse the rest of the body as indicated by client condition. Allow for privacy when the client cleanses the genital region. If the client is unable to cleanse the genitalia, perform the function, insuring privacy during the function.
10. Observe the skin for any lesions or unusual coloration. Assess the degree of independent function and degree of strength of the client.
11. Observe the client for signs of weakness during these procedures. Should the client show any signs of weakness, obtain help by using the emergency call system and discontinue the bathing. Stay with the client.
12. Place bath mat for client as he/she exits the bath or shower. Hold the bath blanket around the client as he/she exits the bath or shower to maintain privacy and prevent chilling.
13. Assist the client to dry, apply deodorant, body lotion or bath powder as needed and to dress for return to the room.
14. Remove materials used in assisting with the tub bath or shower, cleansing the materials as necessary prior to storage.
15. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
16. Invite visitors to return to bedside.
17. Report observations to supervising licensed personnel including condition of client, making particular note of skin condition, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in assisting with tub bath or shower.

Performance of procedure for selected client.

GIVE A PARTIAL AND/OR COMPLETE BED BATH

Perform nursing care to meet basic physical care needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently perform basic daily physical care needs and given the following equipment and materials:

paper	hospital gown
pen	lotion
disposable gloves	nail brush
bed linen	emery board
bath blanket	orangewood stick
laundry bag	brush and comb
bath basin	bedpan or urinal
soap and soap dish	appropriate screening
washcloth	linen bag
face towel	clean gown/robe
bath towel	bed linens

WORK TO BE PERFORMED

Give a partial and/or complete bed bath.

PERFORMANCE CRITERIA

Client is odor-free, clean and dry and will express sense of comfort and feeling of cleanliness.

Observations specified by the supervising licensed personnel and any unanticipated findings will be noted.

Skill will be performed with 100% accuracy.

Assistance with a partial bed bath requires 15 minutes. Assistance with a complete bed bath requires 30-40 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (disposable gloves, bed linen, bath blanket, laundry bag, bath basin, soap and soap dish, washcloth, face towel, bath towel, hospital gown, lotion, nail brush, emery board, orangewood stick, brush and comb and bedpan or urinal), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using the facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment on the overbed table for ease of use and ready access. Position bed at level of comfort for the learner and for client.

5. Close windows and doors; shut off fan to prevent chilling the client.
6. Place towels and linen on chair in proximity to client's bed in order of use. Place linen bag close to work area.
7. Offer bedpan or urinal. Empty and clean receptacle prior to start of bathing.
8. Lower the back of the bed and side rails on the learner's side, if permitted.
9. Loosen top bedclothes. Remove and fold blanket and spread. Place bath blanket over top sheet - remove top sheet by sliding it out from under the bath blanket.
10. Remove client's nightwear. Place institutional linens in linen bag. Store client's personal apparel.
11. Fill bath basin 1/3 to 1/2 full with water that is comfortably warm (110°) to the inside of the wrist of the learner.
12. Assist client to move to the side of the bed closest to the learner.
13. Place face towel over top of the bath blanket to keep it dry. Put on gloves in accord with institutional policy.
14. Make a mitten with the washcloth to cover the learner's hand. This helps maintain an evenly warm temperature of the washcloth and controls the use of the washcloth.
15. Cleanse the face and head area:
    a. Wet the washcloth - wipe eyes, moving from inside to outside of eye area - clean each eye with different part of cloth.
    b. Cleanse the rest of the face, including the ears and area around the ears. Do not use soap on face unless requested to do so by the client. Rinse off soap, if used, and dry.
16. Wash the rest of the client's body systematically as outlined below:
    a. Uncover only one portion of the client's body at any one time.
    b. Cleanse, rinse and dry one portion of the body prior to moving to the next.
    c. Cleanse the extremity on the far side of the body before the one next to the learner.
    d. Maintain privacy for the client.
    e. Change bathing water to maintain cleanliness and warmth.
17. Expose the client's arm next to the learner. Protect bed with bath towel placed underneath arm.
    a. Wash, rinse and dry arm and hand.
    b. Repeat for other arm.
    c. Be sure axillae (armpits) are clean and dry.
    d. Apply deodorant and powder if client requests them or needs them.
18. Care for the hands and nails as necessary. Check with the supervising licensed personnel first to see if there are any special instructions.
    a. Place hands in basin of water. Wash each hand carefully. Rinse and dry. Push cuticle (base of fingernails) back gently while wiping the fingers.
    b. Clean under nails with orangewood stick. Shape with emery board. Be careful not to file nails too closely.
19. Put bath towel over client's chest. Then fold blanket to waist. Under towel:
    a. Wash, rinse and dry chest.
    b. Rinse and dry folds under breasts of female client carefully to avoid irritating the skin.
    c. Powder lightly if necessary in accordance with facility policy.
20. Fold bath blanket down to pubic area (location of external genitalia). Wash, rinse and dry abdomen. Fold bath blanket up to cover abdomen and chest. Slide towel out from under bath blanket.
21. Ask client to flex knee, if possible. Fold bath blanket up to expose thigh, leg and foot. Protect bed with bath towel.
    a. Put bath basin on towel.
    b. Place client's foot in basin.
    c. Wash and rinse leg and foot.
    d. When moving leg, support leg properly.

22. Lift leg and move basin to the other side of the bed. Dry leg and foot. Dry well between toes.
23. Repeat for other leg and foot. Take basin from bed before drying leg and foot.
24. Care for nails as necessary. Apply lotion to feet of client with dry skin.
    a. File nails straight across.
    b. Do not round edges.
    c. Do not push back the cuticle - it is easily injured and infected.
25. Change water at this point even though it may have already been changed.
26. Assist the client to turn on side away from the learner. Help the client to move toward the center of the bed. Place bath towel lengthwise next to client's back.
    a. Wash, rinse and dry neck, back and buttocks.
    b. Use long, firm strokes when washing back.
27. A back rub is usually given at this time.
28. Help client to turn on back.
29. Place a washcloth, soap, basin and bath towel within reach of the client. Have client complete bathing by washing genitalia. Provide privacy during this procedure. Assist the client with care of the genitalia as needed.
    a. When assisting the female client, cleanse from front to back of the perineal area in accordance with female perineal care standard.
    b. When assisting the male client, carefully wash and dry penis, scrotum and groin area in accordance with male perineal care standard. If the penis is not circumcised, draw the foreskin back and be sure entire penis is washed. Replace the foreskin to the natural state.
30. Give range of motion exercises to extremities as instructed by supervising licensed personnel.
31. Provide hair care and oral hygiene as needed.
32. Discard towels and washcloth in laundry bag.
33. Assist client to put on clean gown/robe. (In long-term care facilities, the resident/client should be dressed in their own clothing and footwear which is neat, clean and in good repair.)
34. Remove materials used in assisting with bed bath, cleansing the materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
35. Leave clean washcloth and towels in bedside table or hang in accord with facility policy.
36. Change bed linens according to policy.
37. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
38. Invite visitors to return to bedside.
39. Report observations to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in bathing a client.

Performance of procedure for selected client.

GIVE FEMALE PERINEAL CARE

Perform nursing care to meet basic physical care needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently perform basic daily physical care needs and given the following equipment and materials:

paper	basin with warm water
pen	disposable gloves
bath blanket	bed protector
bedpan and cover	washcloth and towel
soap	appropriate screening

WORK TO BE PERFORMED

Assist a female client with perineal care.

PERFORMANCE CRITERIA

Client will be odor-free, clean and dry and will express sense of comfort and feeling of cleanliness.

Observations specified by the supervising licensed personnel and any unanticipated findings will be noted.

Skill will be performed with 100% accuracy.

Assistance with perineal care requires 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (bath blanket, bedpan and cover, soap, basin with warm water, disposable gloves, bed protector and washcloth and towel), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment on the overbed table for ease of use and ready access. Position bed at level of comfort for the learner.
5. Lower side rail on side where the learner will be working. Be sure opposite side rail is up and secure.
6. Fanfold bedspread and blanket to foot of bed. Cover client with bath blanket and fanfold sheet to foot of bed.
7. Position client on back.
8. Ask client to raise hips while the bed protector is placed underneath client.
9. Offer bedpan to client. If used, remove the bedpan cover and place it on chair.
10. Position bath blanket so only the area between the legs is exposed.
11. Ask client to separate her legs and flex knees.

12. Put on disposable gloves.
13. Wet washcloth, make mitt and apply soap lightly.
14. Use one gloved hand to stabilize and separate the vulva. With the other gloved hand, proceed as follows:
    a. Bring soaped washcloth in one downward stroke along the far side of outer labia to perineum.
    b. Rinse washcloth, remake mitt and rinse area just cleaned.
    c. Repeat two above steps, washing and rinsing in turn the inner far labia, the outer near labia and the inner near labia.
    d. With gloved hands, separate labia. Clean and rinse inner part of vulva to perineum.
    e. Dry washed area with towel.
15. Turn client away from the learner. Flex upper leg slightly if permitted.
16. Make a mitt, wet and apply soap lightly.
17. Expose anal area. Wash area, stroking from perineum to coccyx.
18. Rinse the area well in the same manner.
19. Dry carefully.
20. Return client to back.
21. Remove and dispose of bed protector according to facility policy. Cover client with sheet, blanket and bedspread.
22. Remove materials used in assisting with female perineal care, cleansing the materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
23. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
24. Invite visitors to return to bedside.
25. Report observations to supervising licensed personnel to include observations about condition of skin and perineal area tissue.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in giving female perineal care.

Performance of procedure for selected client.

GIVE MALE PERINEAL CARE

Perform nursing care to meet basic physical care needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently perform basic daily physical care needs and given the following equipment and materials:

paper	basin with warm water
pen	disposable gloves
bath blanket	bed protector
urinal or bedpan	washcloth and towel
soap	appropriate screening

WORK TO BE PERFORMED

Assist a male client with perineal care.

PERFORMANCE CRITERIA

Client will be odor-free, clean and dry and will express sense of comfort and feeling of cleanliness.

Observations specified by the supervising licensed personnel and any unanticipated findings will be noted.

Skill will be performed with 100% accuracy.

Assistance with perineal care requires 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (bath blanket, urinal or bedpan, soap, basin with warm water, disposable gloves, bed protector and washcloth and towel), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Arrange equipment on the overbed table for ease of use and ready access. Position bed at level of comfort for the learner.
5. Lower side rail on side of work; ensure that safety is maintained. Remove top covers, folding them neatly out of work area.
6. Position client on back; cover with bath blanket; place the bed protector under the client.
7. Offer the urinal or bedpan to client. Empty and measure contents as necessary.
8. Position bath blanket so only area between the legs is exposed. Ask the client to separate his legs and flex the knees.

9. Fill basin with warm water. Put on disposable gloves. Wet washcloth, make a mitt and apply soap to washcloth.
10. Grasp penis gently with one hand and, beginning at the meatus, wash in a circular fashion to the base of the penis. If the penis is not circumcised, draw the foreskin back and be sure the entire penis is washed.
11. Wash the scrotum, lifting the scrotum to wash the perineum. Rinse the areas just washed, making sure to remove all soap.
12. Dry the washed area. Replace the foreskin to natural state.
13. Turn the client away from the learner on side, flex the client's top leg to expose the anus.
14. Make a mitt with the washcloth; apply soap to the washcloth. Wash the anal area, stroking from the perineum to the coccyx.
15. Rinse the area well; dry the area.
16. Return the client to his back.
17. Remove materials used in assisting with male perineal care, cleansing the materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
18. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
19. Invite visitors to return to bedside.
20. Report observations to supervising licensed personnel to include observations about condition of penis and perineal area.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in providing male perineal care.

Performance of procedure for selected client.

PERFORM NAIL CARE FOR HANDS AND FEET

Perform nursing care to meet basic physical care needs of selected client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently perform basic daily physical care needs and given the following equipment and materials:

wash basin	orange stick
bath thermometer	emery board/nail file
towels	lotion
washcloth	appropriate screening
emesis basin	disposable gloves
nail clippers	

WORK TO BE PERFORMED

Perform nail care for the client's hands and feet.

PERFORMANCE CRITERIA

Nails will be clean and smooth.

Observations specified by the supervising licensed personnel and any unanticipated findings will be noted.

Skill will be performed with 100% accuracy.

Performance of nail care for hands and feet requires 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (wash basin, bath thermometer, towels, washcloth, emesis basin, nail clippers, orange stick, emery board and/or nail file and lotion), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client, asking visitors to leave while care is given if necessary. Arrange screening as appropriate. Explain procedure to client, family member or caregiver.
3. Wash hands. Disposable gloves are used as necessary.
4. Arrange equipment for ease of use and ready access. Position bed at level of comfort for the learner.
5. Observe hands and/or feet carefully.
6. Put client's hands and/or feet in warm water and soak for 10 minutes. This procedure may be incorporated into bathing procedure.
7. Remove hands and/or feet from water and dry.
8. Use the slanted or blunted end of the orange stick to clean dirt out of the nailbeds and under the nails.
9. Clip nails with clippers, as necessary, and, if not contraindicated, following institutional policy.

10. File and shape nails with the emery board or nail file.
11. Apply lotion to the client's hands or feet, as appropriate.
12. Remove materials used in assisting with nail care, cleansing the materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
13. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
14. Invite visitors to return to bedside.
15. Report observations specified by the supervising licensed personnel and any unanticipated findings.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in performing nail care.

Performance of procedure for selected client.

PREPARE THE OPEN/CLOSED BED

Ensure that comfort and safety of the selected client is preserved when bedmaking is performed.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

paper	two pillowcases
pen	laundry hamper
bed	disposable gloves
cotton drawsheet or turning sheet	two large flat sheets or one large flat sheet and one fitted sheet

WORK TO BE PERFORMED

Prepare an unoccupied open/closed bed.

PERFORMANCE CRITERIA

The bed will be properly made, with linens free of wrinkles, tucked neatly in at the corners and firmly tucked under the mattress.

Skill will be performed with 100% accuracy.

Time required to make an unoccupied bed is 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (cotton drawsheet or turning sheet as needed, two large flat sheets or one large flat sheet and one fitted sheet, two pillowcases, laundry hamper and disposable gloves if needed to handle sheets soiled with blood or body fluids), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Wash hands. Place clean linen on back or arm of chair in order of use.
3. Raise bed to a level for good body mechanics.
4. Loosen all linen from the head of the bed on the far side to the head of the bed on the near side.
5. Fold reusable linens and hang them over a clean chair.
6. Roll all of the soiled linen snugly inside of the bottom sheet and place directly in laundry bag. Do not place them on floor or furniture. Do not hold soiled linens against uniform.
7. Move mattress to head of bed. Place mattress pad even with top of mattress.
8. Place bottom sheet on mattress pad. Fanfold to other side. Lower edge is even with mattress. Large hem is at top of mattress. Hem stitching faces mattress pad.
9. Tuck top sheet under mattress so it is tight and smooth. Make a mitered corner at head of bed (if not using fitted sheets).
10. Place plastic drawsheet (if used) about 14" from mattress top. Fanfold to other side.
11. Place cotton drawsheet over plastic drawsheet, covering the entire plastic drawsheet. Fanfold to other side of bed.

12. Place top sheet on bed, large hem at top; hem stitching is toward outside. Fanfold toward other side.
13. Place blanket on bed. Upper hem is 6-8" from top of mattress. Fanfold to other side.
14. Place bedspread on bed. Upper hem is even with top of mattress. Fanfold toward other side.
15. Tuck in top sheet linens at bottom of bed. Make a mitered corner (if not using fitted sheets).
16. Go to other side of the bed. Miter top corner of bottom sheet, pull bottom sheet tight and tuck under mattress (if not using fitted sheets).
17. Straighten all top linen working from head to foot.
18. Tuck in top linens together. Make a mitered corner (if not using fitted sheets).
19. Turn top bedspread under blanket to make a cuff. Turn top sheet down over bedspread. Hem stitching is down.
20. Put pillowcase on pillow and put on bed. Open end is away from door. Pillowcase seam is toward head of bed.
21. Fanfold top linens to foot of bed (for open bed).
22. Attach the signal light to bed. Lower bed to lowest horizontal position.
23. Wash hands.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles for bedmaking.

Performance of procedure for selected client.

MAKE AN OCCUPIED BED

Ensure that comfort and safety of the selected client is preserved when bedmaking is performed.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is confined to bed and given the following equipment and materials:

- paper
- pen
- bed
- cotton drawsheet or turning sheet
- two pillowcases
- laundry hamper
- two large flat sheets or one large flat sheet and one fitted sheet
- disposable gloves
- appropriate screening
- chair
- mattress pad
- plastic drawsheet
- hamper

WORK TO BE PERFORMED

Ensuring that comfort and safety of the selected client is preserved when bedmaking is performed, make an occupied bed.

PERFORMANCE CRITERIA

The bed will be properly made, with linens free of wrinkles, tucked neatly in at the corners and firmly tucked under the mattress.

Making an occupied bed requires 10-20 minutes.

Skill will be performed with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (cotton drawsheet or turning sheet as needed, two large flat sheets or one large flat sheet and one fitted sheet, two pillowcases, laundry hamper and disposable gloves if needed to handle sheets soiled with blood or body fluids), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Place bedside chair at foot of the bed. Arrange linen on back or arm of chair in order of use.
5. Position bed in high, flat position, if allowed. Lower side rail on learner side of the bed. Keep side rail raised on opposite side of bed.
6. If linens are soiled, put on disposable gloves.
7. Take the bedspread and additional blankets off the bed and fold them over the back of the bedside chair.
8. Leave the client covered with top sheet.
9. Loosen the bottom sheet and draw sheet on learner side of the bed. Turn the client to opposite side of the bed, telling them to hold onto raised side rail if able.

10. Roll bottom linens together to center of bed. Straighten mattress pad if one is used.
11. If new mattress pad is needed, fanfold old mattress pad with rest of bottom linens. Place clean mattress pad on bed. Fanfold toward client.
12. Place bottom sheet on mattress pad (hem stitching down). Fanfold toward client.
13. Miter corner at head of bed (if not using fitted sheets). Tuck sheet under mattress from head to foot of bed.
14. Pull plastic drawsheet toward learner over bottom sheet. Tuck excess drawsheet under mattress, or put on clean plastic drawsheet.
    a. Place on bed about 14" from top of mattress.
    b. Fanfold top part toward client.
    c. Tuck excess drawsheet under mattress.
15. Put cotton drawsheet on so it covers entire plastic drawsheet. Fanfold top part toward client. Tuck excess drawsheet under mattress.
16. Raise side rail and go to other side. Lower side rail.
17. Position client on other side. Adjust pillow.
18. Loosen bottom linens. Continuing to roll together and put in hamper.
19. Straighten and smooth mattress pad.
20. Pull clean bottom sheet toward the learner. Miter corner (if not using fitted sheets). Tuck under mattress starting at head of bed.
21. Pull plastic and cotton drawsheet toward learner. Tuck under mattress together or separately.
22. Position client supine in center of bed.
23. Place clean top sheet over client. Large hem is even with top of mattress and hem stitching is on outside. Ask client to hold onto clean sheet while used sheet is removed. Place soiled/used sheet in hamper.
24. Unfold blanket/spread so it covers client. Upper hem is 6-8 inches from mattress top. Turn top hem of sheet or spread down to cover top of blanket top to form cuff.
25. Lift bottom mattress corner. Tuck under top sheet, blanket and bedspread together. Test linens at foot so ample space is allowed for free movement of feet and lower extremities.
26. Raise side rail and go to other side. Lower side rail.
27. Straighten and smooth top linens. Tuck under mattress and miter corner.
28. Change pillowcase(s).
29. Remove the materials collected while changing the bed. Remove and dispose of gloves according to facility policy.
30. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
31. Invite visitors to return to bedside.
32. Report observations to supervising licensed personnel to include observations about condition of client, making particular note of skin condition, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in making an occupied bed.

Performance of procedure for selected client.

PROVIDE ORAL FLUIDS AND FOODS

Perform nursing care to meet daily nutritional needs as dictated by client condition and as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to independently meet nutritional needs and given the following equipment and materials:

paper	oral hygiene items
pen	tray of food
bedpan/urinal	appropriate screening
wash water	disposable gloves

WORK TO BE PERFORMED

Assist in providing oral fluids and foods.

PERFORMANCE CRITERIA

Following provision of assistance, the client may express fullness and satisfaction.

Client's intake and any baseline deviations will be noted.

Skill will be performed with 100% accuracy.

Providing assistance with food preparation requires 5-20 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (bedpan/urinal, wash water, oral hygiene items and tray of food), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Assist client to prepare to eat (using disposable gloves when necessary):
   a. Use bathroom/bedpan/urinal as needed.
   b. Wash hands and face.
   c. Assist client with oral hygiene.
5. Help client to assume upright position in bed; elevate the head of the bed if allowed. If permitted, assist client out of bed and into a chair.
6. Clear away items from overbed table; make sure environment is safe and clean.
7. Identify client with tray of food for appropriate diet. Place tray on overbed table and arrange food for client's convenience.
8. Assist with cutting items, buttering bread, opening packets and pouring beverages.
9. Remove tray and items as soon as client is finished. Make note of what food and fluids and how much food and fluids were consumed.
10. Record fluids on intake record and/or provide calories count, if necessary.
11. Push overbed tray out of the way and return any items requested by client. Assist client as necessary to wipe mouth and cleanse hands.

12. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
13. Invite visitors to return to bedside.
14. Report observations to supervising licensed personnel to include observations about condition of client, amount and type of food eaten, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for providing oral fluids and foods.

Performance of procedure for selected client.

PERFORM INTERMITTENT AND CONTINUOUS GASTROSTOMY/ NASOGASTRIC FEEDINGS

(Licensed Practical or Registered Nurse)

Perform nursing care to meet daily nutritional needs as dictated by client condition and as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with a nasogastric tube in place for feeding but unable to independently meet nutritional needs and given the following equipment and materials:

paper	measuring container
pen	appropriate screening
prescribed enteral nutrition	disposable gloves
proper equipment	towel
20-50 ml. syringe	clamp
60 ml. water at room temperature	emesis basin
correct amount and type of feeding	

WORK TO BE PERFORMED

Provide prescribed enteral nutrition using proper equipment.

Following administration of the feeding, the client will remain in an upright position (30°-60°) for 20-30 minutes. The client's tolerance of the feeding and any baseline deviation will be noted.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time for administering the enteral nutrition will vary dependent upon client tolerance, method of administration, type and amount of feeding.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment as needed (correct amount and type of feeding ordered for the particular client, 20-50 ml. syringe, emesis basin for aspirated stomach contents, measuring container for feeding and 60 ml. water at room temperature), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening.
3. Wash hands. Put on disposable gloves. Explain procedure to client, family member or caregiver.
4. Check feeding to ensure it is at room temperature and fresh (opened within 24 hours of use) or is not beyond the expiration date if a commercial preparation.
5. Position client in an upright position or with head of bed elevated at least 30°; unclamp the tubing that is in place and assess for tube placement. Place towel or other cover to prevent soiling of clothing and/or bed clothes.

6. Measure gastric volume to determine any degree of retention. If the amount returned is less than 100 ml., return to the stomach followed by 50 ml. of water. If the volume aspirated from the stomach is more than 100 ml., report to the supervising licensed personnel. (The parameters for residual will vary with the institution.)
7. Attach the 50-60 ml. syringe for a bolus feeding to the end of the nasogastric tube. Clamp the tubing to prevent air moving into the stomach, fill the barrel of the syringe, hold the syringe approximately 10" above the level of the stomach, unclamp the tubing and allow the feeding to flow by gravity.
8. Monitor the client while the feeding is flowing for cramping, feeling of fullness or nausea. Stop the flow and/or slow the feeding if intolerance or discomfort is detected.
9. Follow the feeding with 50 ml. of water to flush the feeding and provide fluid in addition to the feeding.
10. Disconnect the syringe from the nasogastric tubing, clamp or plug the tubing and cover the end of the tubing and attach securely to client's gown.
11. Remove the materials used for the feeding, cleansing the materials as necessary prior to storage.
12. Restore client to comfortable and safe position with head of bed elevated. Leave signal cord, telephone and fresh water (if allowed) close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
13. Invite visitors to return to bedside.
14. Report observations to supervising licensed personnel to include observations about condition of client, amount of feeding and water taken, tolerance of feeding, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for performing intermittent and continuous gastrostomy/nasogastric feedings.

Performance of procedure for selected client.

MAINTAIN PATENCY OF A GASTROSTOMY/ NASOGASTRIC TUBE

(Licensed Practical or Registered Nurse)

Perform nursing care to meet daily nutritional needs as dictated by client condition and as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is alert with a nasogastric tube in place for drainage and given the following equipment and materials:

paper	emesis basin
pen	appropriate screening
disposable gloves	stethoscope
bulb syringe with barrel	cotton-tipped applicators
30 ml. normal saline	water soluble lubricant
towel	tape

WORK TO BE PERFORMED

Assess adequacy of a gastrostomy/nasogastric tube and placement and condition of the client maintaining safety and privacy.

PERFORMANCE CRITERIA

Steps of problem solving will be evident in the condition report given to the supervising licensed personnel.

Patency and adequacy of the drainage system will be maintained. Integrity of the skin surfaces will be maintained.

Skill will be performed with 100% accuracy.

Providing care directed to maintaining adequacy of the drainage system requires 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (disposable gloves, bulb syringe with barrel, 30 ml. normal saline, towel and emesis basin), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening.
3. Wash hands. Put on disposable gloves. Explain procedure to client, family member or caregiver.
4. Evaluate color and characteristics of drainage in tubing. Check placement of tubing in stomach by accepted methods:
   a. Using a stethoscope, listen over the epigastric area of the abdomen while injecting 10 ml. of air into tube. Air will make a rushing sound.
   b. Aspirate tubing checking for gastric contents.
   c. Ask conscious client to talk and hum. Client will be able to talk and hum.
   d. Note color of client's skin; color should be normal.
5. Disconnect tubing from suction apparatus or unclamp tubing.

6. Irrigate nasogastric tube with 30 ml. normal saline - in accord with agency protocol or in accord with physician's directives.
7. Follow agency protocol for recording irrigation solution and nasogastric drainage on intake and output record.
8. Inspect nostril of tube insertion for irritation, crusting and/or discharge.
9. Cleanse the nostril and tube with moistened, cotton-tipped applicators.
10. Apply water-soluble lubricant to the nostril if it appears dry or encrusted.
11. Change the tape as required - secure the tube by taping it to the bridge of the client's nose - cut a 3" piece of tape and split it at one end, leaving 1" at the end. Place the unsplit end over the bridge of the client's nose, and bring the split ends under the tubing and back up over the nose.
12. Give frequent mouth care.
13. Remove materials used to maintain patency of a nasogastric/gastrostomy tube, cleansing materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
14. Restore client to comfortable and safe position. Leave signal cord and telephone close at hand. Make sure bed is in lowest position permitted, remove screening used for privacy, remove any soiled linens and wash hands.
15. Invite visitors to return to bedside.
16. Report observation to supervising licensed personnel. This report should include observations about the character of nasogastric drainage, observations about skin condition of nostril and client tolerance of tube placement.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for maintaining patency of a gastrostomy/nasogastric tube.

Performance of procedure for selected client.

CARE FOR AND MONITOR PERIPHERAL INTRAVENOUS THERAPY SITE

(Licensed Practical or Registered Nurse)

Perform nursing care to meet daily nutritional needs as dictated by client condition and as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with an intravenous infusion site and given the following equipment and materials:

paper	gloves
pen	appropriate screening
agency protocol will dictate equipment	

WORK TO BE PERFORMED

Care for and monitor peripheral intravenous therapy site involving peripheral intravenous therapy.

PERFORMANCE CRITERIA

Principles of asepsis and safety will be followed when giving care for an intravenous infusion site.

Nursing Process will be used to determine status of intravenous infusion site. Institutional protocol will guide care provided following diagnosis of need.

Following care of the intravenous infusion site, the client will be in a safe and comfortable position.

Provide care for three intravenous infusion sites with supervision with 100% accuracy.

Time required for care will vary according to client condition but should not exceed 10 minutes excluding time for documentation.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment as needed, go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands. Gloves should be used.
4. Inspect the intravenous insertion site for signs of infection, infiltration or dislocated needle.
5. Inspect the surrounding skin for redness, pallor or swelling.
6. Palpate the surrounding tissues for coldness and presence of edema, which could indicate leakage of the IV fluid into the tissues.
7. Cleanse and redress the intravenous insertion site following agency protocol.
8. Remove materials used in providing care for the intravenous insertion site and dispose of properly according to universal precautions and facility protocol. Remove and dispose of gloves according to facility policy.

9. Ensure client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; wash hands.
10. Invite visitors to return to bedside.
11. Report observations to supervising licensed personnel. Include observations about appearance and condition of intravenous insertion site and client tolerance of procedure.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for care and monitoring peripheral intravenous therapy site.

Performance of procedure for selected client.

ASSIST WITH USE OF THE BEDPAN

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently handle elimination needs and given the following equipment and materials:

paper	toilet tissue
pen	soap
bedpan and cover	towel
basin of warm water	appropriate screening
washcloth	waste container
disposable gloves	

WORK TO BE PERFORMED

Assist with use of the bedpan in a safe manner while providing privacy for the client.

PERFORMANCE CRITERIA

Following assistance, the client will express relief of the need for elimination.

Amount and characteristics of urine and stool will be noted. Characteristics of elimination process will be noted.

Skill will be performed with 100% accuracy.

Assistance with use of the bedpan requires 5-15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (bedpan and cover, basin of warm water, washcloth, disposable gloves, toilet tissue, soap and towel), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to the client, family member or caregiver.
3. Wash hands.
4. Place the bedpan on a chair. Place toilet tissue in easy reach of the client.
5. Raise the bed to a comfortable working level. Lower the headrest if this is tolerated by the client.
6. Warm a metal bedpan by running warm water into it and then discarding the water. Plastic bedpans may not need to be warmed.
7. Lower side rails on the side of the learner, ensuring safety of the client.
8. Put on disposable gloves. Fold top covers back to provide room to place the bedpan without undue exposure of the client.

9. Ask the client to flex the knees and raise the buttocks. Assist the client to raise the buttocks as needed by placing a hand under the small of the back and lifting while at the same time sliding the bedpan into place.
   (If the client is unable to lift or be lifted, roll him/her away from the learner and place the bedpan against the buttocks, holding it in place as the client is returned to their back, positioned on the bedpan.)
10. Position the client correctly on the bedpan to prevent spillage.
11. Replace the top covers. Raise the head of the bed to enhance comfort and ability to use the bedpan effectively. Place the call bell and toilet tissue within easy reach.
12. Raise the siderail and lower the bed before leaving the client. Instruct him/her to press the call button when finished with using the bedpan.
13. Answer the call light promptly. Raise the bed and lower the siderail on the side of the learner. Assist the client to raise the buttocks. Remove the bedpan, making sure that skin of the buttocks is not stuck to the bedpan.
14. Cover the bedpan and set it aside on a chair or at the bottom of the bed. Clean the genital area wiping from front to back and dropping the tissue in the bedpan unless contraindicated.
15. Put soiled tissue in bag or waste container if specimen is collected. Dispose in toilet.
16. Fill basin with warm water to assist the client with handwashing and other cleansing as requested.
17. Reposition the client and replace bedcovers. Lower the bed to a safe level.
18. Ensure privacy and safety of client prior to taking bedpan to bathroom to dispose of contents.
19. Observe amount, color and type of contents. Measure contents of bedpan if needed. Collect a specimen if instructed to do so.
20. Empty contents of the pan into the toilet and rinse with cold water.
21. Return bedpan to unit. Carry bedpan with cover in place.
22. Remove materials used in assisting with bedpan use, cleansing the materials as needed prior to storage. Remove and dispose of gloves according to facility policy.
23. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens and wash hands.
24. Invite visitors to return to bedside.
25. Report observations to supervising licensed personnel. Include observations about condition of client, making particular note of characteristics of feces and urine and if collection of specimen was completed as ordered.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for assisting with use of the bedpan.

Performance of procedure for selected client.

ASSIST WITH USE OF THE BEDSIDE COMMODE

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently handle elimination needs and given the following equipment and materials:

paper	washcloth
pen	soap
portable commode	towel
toilet tissue	disposable gloves
basin of warm water	appropriate screening

WORK TO BE PERFORMED

Assist with using the bedside commode in a safe manner while providing privacy for the client.

PERFORMANCE CRITERIA

Following assistance, the client will express relief of the need for elimination.

Amount and characteristics of urine and/or stool will be noted. Any unanticipated problems with use of the commode will be reported.

Skill will be performed with 100% accuracy.

Assistance with using the bedside commode requires 10-15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (portable commode, toilet tissue, basin of warm water, washcloth and soap, towel and disposable gloves), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Position commode beside the bed in a manner that accommodates client abilities. Lock wheels and remove the cover. Be sure receptacle is placed under seat. Leave a little water in bottom of receptacle if specimen is not to be collected.
5. Lower side rails on side of learner; lower bed to lowest horizontal position; ensure stable position.
6. Assist the client to sitting position. Put slippers on feet. Assist the client to stand maintaining safety. Pivot the client and help him/her sit on the commode.
7. Place call light and toilet tissue within reach of the client. Assure privacy and leave the client if possible. Instruct client to call when finished. Return promptly in response to the call light; check on client within five minutes if no call light.

8. Wash hands. Assist the client to use toilet tissue. Assist the client to return to bed or chair as appropriate.
9. Provide washcloth, soap and towel for client to wash hands.
10. Put on disposable gloves. Remove receptacle from commode; check excreta for appearance; collect specimen if required; measure output if required.
11. Empty contents of receptacle into toilet. Rinse receptacle with cold water. Replace receptacle in commode.
12. Remove materials used in assisting with use of the commode, cleansing the materials as needed prior to storage.
13. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
14. Invite visitors to return to bedside.
15. Report observations to supervising licensed personnel. Include specific information about urine and stool characteristics. Report any unanticipated problems with client using the commode.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for use of bedside commode.

Performance of procedure for selected client.

ASSIST WITH USE OF THE URINAL

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently meet elimination needs and given the following equipment and materials:

- paper
- pen
- urinal
- basin of warm water
- soap
- washcloth
- towel
- disposable gloves
- appropriate screening

WORK TO BE PERFORMED

Assist with use of the urinal in a safe manner while providing privacy for the client.

PERFORMANCE CRITERIA

Following assistance, the client will express relief of the need for elimination.

Amount and characteristics of the urine and any difficulties voiding will be noted.

Skill will be performed with 100% accuracy.

Assistance with using the urinal requires 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (urinal, basin of warm water, soap, washcloth, towel, disposable gloves), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Put on gloves. Lift the bed covers and place the urinal so that the client can grasp it by the handle. If the client is unable to do this independently, the learner will place the penis in the urinal and ensure it is stable in place.
5. Remove the gloves; place the call light button within easy reach. Instruct the client to use the call button when he is finished. Provide privacy. Watch to see the call light come on; return promptly to the bedside.
6. Provide warm water, soap and wash cloth so client can cleanse hands as necessary.
7. Put on gloves. Ask client to give the urinal to the learner. Cover the urinal. Rearrange the bedclothes.
8. Take the urinal to the bathroom or utility room to empty. Observe the contents of the urinal. Don't empty if there are foreign materials; call supervising licensed personnel to assess the urine.
9. Empty the urinal; measure and record the contents if needed.

10. Remove materials used in assisting with use of the urinal, cleansing the materials as needed prior to storage. Remove and dispose of gloves according to facility policy.
11. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens and wash hands.
12. Invite visitors to return to bedside.
13. Report observations to supervising licensed personnel including observations about condition of client, making particular note of characteristics of urine.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for using the urinal.

Performance of procedure for selected client.

INSERT AND MAINTAIN PATENCY OF AN INDWELLING CATHETER

(Licensed Practical or Registered Nurse)

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who needs an indwelling catheter and given the following equipment and materials:

paper
pen
gloves
drapes
antiseptic solution
cotton balls/gauze
trash bag
forceps
water-soluble lubricant
catheter
receptacle for urine
specimen container
appropriate screening
bath blanket
clamp

WORK TO BE PERFORMED

Insert an indwelling catheter for continuous drainage using appropriate equipment in an aseptic manner, providing privacy for the client.

PERFORMANCE CRITERIA

Principles of asepsis will be demonstrated.

Amount and characteristics of the urine, the client's tolerance of the procedure and unusual findings will be noted.

Skill will be performed with 100% accuracy.

Insertion of a catheter for continuous drainage will require a minimum of 10-15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Become familiar with different techniques used for male and female catheterization.
2. Assemble equipment -- most generally components of a kit plus additional draping and equipment -- (gloves, drapes, antiseptic solution, cotton balls or gauze squares, trash bag, forceps, water-soluble lubricant, catheter, receptacle for urine and specimen container if needed), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
3. Explain the procedure clearly to the client in order to gain cooperation. Explain the sensation of pressure, not one of pain.
4. Provide for privacy of the client. Arrange appropriate screening.
5. Wash hands.
6. Assist the client to assume a dorsal recumbent position, with knees flexed and thighs externally rotated.
7. Drape the client, using a bath blanket to cover the abdomen and chest. An additional sheet or bath blanket should be used to cover the thighs and legs.

8. Wash the perineal - genital area. Dry the area.
9. Position trash bag within reach. Ensure that sufficient light is available to view the meatus.
10. Open the sterile kit. Don the sterile gloves and remove the drapes provided with the kit. Cuffing one drape over the gloves to maintain sterility, place one drape on bed, between the thighs and under the buttocks.
    a. Some kits and procedures are set so that the first drape is placed under client's buttocks without sterile gloves. Touch only corners of drape. Apply sterile gloves and place fenestrated drape.
11. Place additional drapes in such a way that only the urinary meatus is exposed, using either a fenestrated drape or using non-fenestrated drapes in such a way that a sterile field is produced with the urinary meatus exposed.
12. Pour antiseptic solution over the cotton balls to be used for cleansing. Check for patency of the catheter balloon by inflating and deflating. Lubricate the tip of the catheter (approximately 1½ - 2"). Beyond this point, one hand of the learner will be contaminated by contact with the client, while the other hand will be used to manipulate the materials used for catheterization.
13. For the female client:
    a. Place the receptacle kit on the drape between the thighs if possible. This will facilitate using the supplies and place the receptacle in place to catch the urine.
    b. Using the thumb and forefinger, separate the labia majora. Using the cotton balls soaked with antiseptic solution, cleanse the area, using one swipe per cotton ball, going from front to back. Discard the cotton balls onto the drape, being careful not to contaminate the remaining supplies.
    c. With the same hand, separate the labia minora. Using additional cotton balls with antiseptic solution, cleanse around the meatus, using downward strokes on each side of the meatus. Discard each cotton ball after one stroke. Once the meatus is cleansed, the labia cannot be allowed to close.
    d. Using the non-contaminated, gloved hand, pick up the catheter, holding it 2-3" from the insertion tip. Be sure to control the movement of the catheter in order not to contaminate the catheter. Allow the open end of the catheter to hang in the collection basin.
    e. Insert the catheter into the meatus, advancing it until it meets resistance or until urine begins to flow. If resistance is encountered, ask the client to take several deep breaths to aid with relaxation. If resistance continues, discontinue the procedure and seek assistance. If urine begins to flow, advance catheter 1" further.

    For the male client:
    a. Place the receptacle kit on the drape between the thighs if possible. This will facilitate using the supplies and place the receptacle in place to catch the urine.
    b. Clean the meatus using the swabs/cotton balls saturated with antiseptic solution. Grasp the penis firmly beneath the glans and spread the meatus between the thumb and forefinger. Retract the foreskin of the uncircumcised male. The hand holding the penis is now contaminated. The meatus is cleansed by using sterile forceps to pick up a swab, cleansing the meatus first, then using a circular motion to cleanse the tissue surrounding the meatus. Discard the cotton balls onto the drape, being careful not to contaminate the remaining supplies.
    c. Using the non-contaminated, gloved hand, pick up the catheter, holding it 2-3" from the insertion tip. Be sure to control the movement of the catheter in order not to contaminate the catheter. Allow the open end of the catheter to hang in the collection basin.
    d. Lift the penis perpendicular to the body and exert slight traction. This movement straightens the urethra and aids catheter insertion. Insert the catheter into the meatus, advancing it until it meets resistance or until urine begins to flow.
    If resistance is felt, ask the client to take several deep breaths in an attempt to relax. If resistance continues, discontinue the procedure and seek assistance. Replace foreskin to cover the glans.

14. Holding the catheter in place, allow the urine to drain and/or collect a specimen if required.
15. Insertion of an indwelling catheter will follow the same procedure. Additional equipment will include an indwelling catheter and a syringe with fluid to inflate the balloon which holds the catheter in place. The balloon should be tested prior to inserting the catheter to be sure it will inflate appropriately and not leak.
16. Remove the straight catheter following drainage of the bladder or with collection of 750 ml. of urine. If the bladder is not empty at the 750 ml. level, catheter will be clamped. Agency policy will dictate the level of urine removed at one time and the follow-up procedures.
17. Inflate the balloon of an indwelling catheter when certain the catheter is in the bladder. After inflation, gently pull on catheter until resistance is met.
18. Attach the indwelling catheter to a collection receptacle. The unit may come complete as a closed system. The catheter will be looped and taped to the client's thigh or abdomen in the male client. The tubing will be looped on the bed to drain straight to the receptacle which is hung on the side of the bed.
19. Cleanse the perineal area and make the client comfortable.
20. Remove materials used in the catheterization procedure. Dispose of materials in accord with facility protocol.
21. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens and wash hands.
22. Invite visitors to return to bedside.
23. Report observations to supervising licensed personnel, including condition of client, ease of catheterization, amount and character of urine.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for inserting and maintaining patency of an indwelling catheter.

Performance of procedure for selected client.

ASSIST WITH CARE OF INDWELLING CATHETER

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who has an indwelling catheter, provided with standard equipment and given the following equipment and materials:

paper	catheter care kit
pen	antiseptic solution
disposable gloves	sterile applicators
bed protector	tape
bath blanket	measuring graduate
plastic bag for disposable items	appropriate screening

WORK TO BE PERFORMED

Assist with routine care of the indwelling catheter in a safe manner providing for privacy of the client.

PERFORMANCE CRITERIA

Following assistance, the meatus will be clean and free of secretions.

Amount and characteristics of the urine and any unusual findings will be noted.

Care will be provided as necessary and in accord with facility policy. Assistance with care of an indwelling catheter requires 10-15 minutes, most commonly associated with morning care.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (disposable gloves, bed protector, bath blanket, plastic bag for disposable items, catheter care kit, antiseptic solution, sterile applicators and tape), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Be sure opposite side rail is up and secure. Position client in dorsal recumbent, lithotomy position.
5. Cover client with bath blanket and fanfold bedding to foot of bed.
6. Ask client to raise hips; place bed protector underneath client.
7. Position bath blanket so that only genitals will be exposed.
8. Arrange catheter care equipment and plastic bag on overbed table; prepare equipment for use.
9. Put on gloves and draw drape back.

10. For the male client:
    a. Gently grasp penis and draw foreskin back, if not circumcised.
    b. Using an applicator dipped in antiseptic solution for each stroke, cleanse the glans from meatus toward shaft for approximately 4 inches.
    c. Dispose of each used applicator in plastic bag after one stroke.
    d. Use a new, freshly dipped applicator for each stroke.

    For the female client:
    a. Separate the labia.
    b. Using an applicator freshly dipped in antiseptic, stroke from front to back.
    c. Dispose of each used applicator in plastic bag after one stroke.
11. Remove gloves and discard in plastic bag.
12. Check catheter to be sure it is taped properly. Retape and adjust for slack, if needed.
13. Check to be sure tubing is coiled on bed and hangs straight down into drainage container. Check level of urine in container. End of tubing should not be below urine level. Empty bag and measure, if necessary. Do not raise bag above level of tubing.
14. Dispose of materials used in caring for an indwelling catheter following facility protocols. Remove and dispose of gloves according to facility policy.
15. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
16. Invite visitors to return to bedside.
17. Report observations to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation pertaining to indwelling catheters.

Performance of procedure for selected client.

MEASURE CONTENTS OF A URINARY DRAINAGE UNIT AND EMPTY

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who has a urinary drainage unit, provided with standard equipment and given the following equipment and materials:

- paper
- pen
- graduated measuring container
- disposable gloves
- sterile cap or sterile 4 X 4
- alcohol swab
- appropriate screening

WORK TO BE PERFORMED

Measure and empty the amount of urine collected in the unit aseptically providing privacy for client.

PERFORMANCE CRITERIA

Amount and characteristics of the urine will be noted.

Skill will be performed with 100% accuracy.

Measuring the amount of urine and emptying the urinary drainage unit requires 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (graduated container, disposable gloves, sterile cap or sterile 4 X 4 and alcohol swab), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Put on gloves.
5. Place a graduate under drainage bag, if drain is in the bottom.
6. Open drain and allow the urine to drain into the graduate. Do not allow the tip of the tubing to touch the sides of the graduate.
7. Close the drain and wipe it with the alcohol swab. Replace it in the holder.
8. Exercise care to maintain aseptic technique and utmost cleanliness when emptying the bag and handling any tubing connections.
9. Note the amount and character of urine.
10. Position the drainage tube to ensure free drainage.
11. Take graduate to bathroom and empty it.
12. Remove materials used to empty the urinary drainage unit, cleansing the materials as needed prior to storage. Remove and dispose of gloves according to facility policy.
13. Make sure client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.

14. Invite visitors to return to bedside.
15. Report observations to supervising licensed personnel. Make particular note of character and amount of urine.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for measuring urinary drainage.

Performance of procedure for selected client.

GIVE A TAP WATER ENEMA

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to routinely and independently meet elimination needs or for whom this treatment has been ordered and given the appropriate equipment and materials:

- paper
- pen
- enema equipment
- disposable gloves
- bedpan and cover
- bed protector
- toilet tissue
- bath blanket
- washcloth and towel
- soap
- basin with water
- lubricant
- clamp
- appropriate screening

WORK TO BE PERFORMED

Give an enema using standard equipment in a safe manner providing privacy for the client.

PERFORMANCE CRITERIA

Results of the enema will be noted and reported to supervising licensed personnel.

Skill will be performed with 100% accuracy.

The enema procedure will not exceed 45 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (enema equipment as determined by type of enema to be administered, disposable gloves, bedpan and cover, bed protector, toilet tissue, bath blanket, washcloth, towel, soap, basin with water, and lubricant), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to the client, family member or caregiver.
3. Wash hands.
4. Instruct the client to empty bladder. Assist as necessary.
5. Position bed in horizontal position.
6. Prepare solution (approximately one liter) to be administered; temperature should be approximately 105° F.
7. Run solution into tubing to remove air from tubing. Place container with solution 12-18" above client.
8. Position underpad beneath client's buttocks.
9. Position client in left side lying position or on back with bedpan under buttocks and with knees flexed as condition dictates.
10. Lubricate 1-2" of tip of enema tubing.

11. Put on gloves. Spread client's buttocks and insert tube slowly and gently about 4" into rectum. Never force the tube. If tube cannot be inserted easily, obtain assistance from supervising licensed personnel.
12. Administer the solution, assessing the client to ensure comfort with the administration of solution. Stop flow of solution if client expresses discomfort.
13. Clamp and remove tubing when client can retain no more solution; wrap tubing in underpad.
14. Place client on bedpan or commode chair or assist to bathroom. Raise head of bed to comfortable height if client is on bedpan.
15. Place toilet tissue and call button within easy reach.
16. Instruct client to call for assistance when finished evacuating the enema solution. Caution not to flush the toilet if in the bathroom.
17. Return to bedside when summoned. Assist the client with use of toilet tissue and to cleanse the anal area as needed. Remove the bedpan or assist the client to return to bed.
18. Provide warm water, washcloth and towel to cleanse hands.
19. Observe the contents of the bedpan or toilet bowl. Make note of characteristics of any feces expelled with enema solution.
20. Empty bedpan into toilet and/or flush toilet.
21. Remove and/or discard materials used in administering the enema, cleansing any reusable materials as needed prior to storage. Remove and dispose of gloves according to facility policy.
22. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
23. Invite visitors to return to bedside.
24. Report observations to supervising licensed personnel. Report should include information about condition of client, tolerance of procedure and character of feces and enema return.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for administering an enema.

Performance of procedure for selected client.

Perform nursing care that assists the selected client with elimination as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with an ostomy and given the following equipment and materials:

- pen
- paper
- solvent for appliance removal
- receptacle for soiled appliance
- tissue
- warm water
- mild soap
- wash cloth
- towel
- skin barrier
- measuring guide
- scissors
- closure device
- adhesive
- deodorant
- tape
- provisions for privacy
- disposable gloves
- ostomy belt
- waste container

WORK TO BE PERFORMED

Assist with ostomy care in an aseptic manner, providing for safety of the client.

PERFORMANCE CRITERIA

Characteristics of ostomy discharge and condition of the surrounding skin will be noted.

Skill will be performed with 100% accuracy.

Time required for ostomy care will depend on the type of ostomy, condition of the skin and extent of orders. Time ordinarily needed for care will be 15-30 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. An ostomy differs in its position, the nature of discharge from the ostomy and the potential for skin problems. Describe the type of ostomy in order to anticipate the type of care needed and the potential for problems.
2. Care needs will differ according to the type of ostomy. General principles apply and are included as part of the criteria. Data collection will include
   a. Characteristics of the stoma - placement on abdominal wall, color of the stoma and size of the stoma;
   b. Skin characteristics - color, smoothness, irritation, any skin breakdown;
   c. Type and nature of stoma discharge;
   d. Integrity of the appliance - seal with the skin.
3. Assemble equipment (solvent for appliance removal, receptacle for soiled appliance, tissue, warm water, mild soap, wash cloth, towel, skin barrier, measuring guide, scissors, closure device, adhesive, deodorant if needed, tape), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.

4. Provide for privacy of the client, asking visitors to leave while care is given if necessary. Arrange screening as appropriate.
5. Wash hands. Put on disposable gloves. Explain procedure to the client, family member or caregiver.
6. Assist the client to the bathroom if possible. If the client is unable to move to the bathroom, he/she should be as upright in bed as possible.
7. Unfasten and remove the ostomy belt if one is worn. Empty the appliance if it is 1/3 to 1/2 full. Characteristic of the effluent should be noted.
8. Remove the appliance. Cleanse the skin with solvent if necessary. Wash around the stoma area with warm water and soap as needed. Dry the skin. Cover the stoma with tissue to catch any effluent during care.
9. Assess the stoma as well as the peristomal skin.
10. Prepare and apply the skin barrier. Follow instructions with the specific type of skin barrier.
11. Measure the stoma and make a template of its size and shape. Cut the appliance to fit the stoma, using the template with minimal skin area exposed.
12. Position and seal the appliance in place. Check for tight seal without wrinkles or gaps.
13. Deodorant may be placed in bag. Remove air from appliance prior to closing the opening.
14. Remove materials used in assisting with ostomy care, cleansing the materials as needed prior to storage. Remove and dispose of gloves according to facility policy.
15. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
16. Invite visitors to return to bedside.
17. Report observations to supervising licensed personnel. Those observations will include information about the stoma, the nature of effluent and the condition of peristomal skin.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for providing ostomy care.

Performance of procedure for selected client.

MEASURE AND RECORD ORAL TEMPERATURE, RADIAL PULSE AND RESPIRATIONS

Gather, report and record accurate information about client vital signs as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

- pen
- paper
- oral thermometer
- thermometer holder
- plastic covers for thermometers
- thermometer wipes
- tissues
- watch with second hand
- appropriate screening

WORK TO BE PERFORMED

Gather and record vital signs inclusive of oral temperature, radial pulse and respirations.

PERFORMANCE CRITERIA

The vital signs and general condition will be reported to the supervising licensed personnel.

Skill will be performed with 100% accuracy.

Time required to measure and record oral temperature, radial pulse and respirations is 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (oral thermometer and thermometer holder, tissues, paper and pen, thermometer wipes, plastic covers for thermometers and watch with second hand), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet. Ask client not to eat, drink, smoke or chew gum for 15 minutes prior to having oral temperature taken.
2. Provide for privacy of the client. Arrange screening as appropriate. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Position client comfortably in bed or chair.
5. Remove thermometer from container by holding stem end. Wipe with tissue. Check to be sure the thermometer is intact. Read the mercury column. It should register below 96° F. If necessary, shake down. (When shaking the thermometer, make sure there is sufficient room. Move away from table or bed.) Use sharp downward motion to shake down mercury.
6. After placing thermometer in cover, insert bulb end of thermometer under client's tongue, toward side of mouth. Ask client to hold thermometer gently with lips closed for three minutes.
7. Remove thermometer, holding by stem. Wipe from stem end toward bulb end, removing cover if one is used.
8. Discard thermometer wipes and cover in proper container. Read thermometer and record.

9. Care for the thermometer according to facility policy.
10. Take the radial pulse and count the respirations, the palm of the client's hand should be down and the arm should rest across the client's chest.
11. Locate the pulse on the thumb side of the wrist with the tips of the learner's first three fingers.
12. Exert slight pressure when the pulse is felt. Use second hand of watch and count for one minute. (It is the practice in some facilities to count for 30 seconds and multiply by two and record the rate for one minute.) A one-minute pulse is preferred and must be done if the pulse is irregular.
13. Leave the fingers on the radial pulse and count the number of times the chest rises and falls for one minute after the pulse has been counted.
14. Note depth and regularity of respirations.
15. Record the temperature and the rate, depth and regularity of respirations and pulse.
16. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
17. Invite visitors to return to bedside.
18. Report observations to supervising licensed personnel to include observations about condition of client, making particular note of any difference in vital sign readings from previous readings or vital signs unable to be recorded for any reason.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for measuring temperature, pulse and respirations.

Performance of procedure for selected client.

COUNT, RECORD AND REPORT APICAL PULSE

Gather, report and record accurate information about client vital signs as directed by the supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

paper	cleansing materials
pen	watch with second hand
stethoscope	appropriate screening

WORK TO BE PERFORMED

Take, record and report the apical pulse in a safe manner, providing for privacy of the client.

PERFORMANCE CRITERIA

Following recording of the apical pulse, the learner will report the pulse to the supervising licensed personnel with observations related to blood supply to body.

Skill will be performed with 100% accuracy.

Time required to take, record and report the apical pulse rate and characteristics is 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (stethoscope, cleansing materials and watch with second hand), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Clean stethoscope earpieces and bell with disinfectant.
5. Place stethoscope earpieces in the ears.
6. Raise gown or open pajamas to expose chest. Keep rest of body covered.
7. Place the stethoscope diaphragm or bell over the apex of the client's heart. (If the bell is cold, warm it in the hand prior to making contact with the client's skin.)
8. Listen carefully for the heartbeat.
9. Count the louder sounding beats for one minute.
10. Check radial pulse for one minute. Compare the two measures. Make note of any difference.
11. Remove the materials used in taking the apical pulse, cleansing the materials as necessary prior to storage. Remove and dispose of gloves (if used) according to facility policy.
12. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.

13. Invite visitors to return to bedside.
14. Report observations to the supervising licensed personnel about condition of client, including any pulse deficit.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for counting apical pulse.

Performance of procedure for selected client.

MEASURE AND RECORD AXILLARY TEMPERATURE

Gather, report and record accurate information about client vital signs as directed by the supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is unable to tolerate having the temperature taken by oral or rectal means and given the following equipment and materials:

- pen
- paper
- plastic sheaths for thermometers
- container for used thermometers
- container for soiled tissues
- watch with second hand
- appropriate screening
- container with clean oral thermometers

WORK TO BE PERFORMED

Measure and record the temperature taken in the axilla in a safe manner, providing for the privacy of the client.

PERFORMANCE CRITERIA

Following the measuring and recording of the axillary temperature, report findings to the supervising licensed personnel.

Skill will be performed with 100% accuracy.

Time required will be 10-15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (container with clean oral thermometers, plastic sheaths for thermometers, container for used thermometers, container for soiled tissues and watch with second hand), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member and caregiver.
3. Wash hands.
4. Check thermometer. Shake down if needed.
5. Wipe the axilla area dry and place the thermometer with sheath applied in the axillary region with the arm close to the body.
6. Leave the thermometer in place for 10 minutes.
7. Remove sheath, wipe and read the thermometer. Record the reading with an "A" for axillary.
8. Remove the materials used in recording the temperature, cleansing the materials as necessary prior to storage. Remove and dispose of gloves (if used) according to facility policy.
9. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.

10. Invite visitors to return to bedside.
11. Record results following agency policy.
12. Report observations to supervising licensed personnel to include observations about condition of client, making particular note of skin condition, appearance and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for measuring axillary temperature.

Performance of procedure for selected client.

MEASURE AND RECORD RECTAL TEMPERATURE

Gather, report and record accurate information about client vital signs as directed by the supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client for whom an oral temperature would not be possible or may be inaccurate and given the following equipment and materials:

- paper
- pen
- container for used thermometers
- container for soiled tissues
- appropriate screening
- lubricant
- container with tissues
- watch with second hand
- disposable gloves
- container with clean rectal thermometer

WORK TO BE PERFORMED

Measure and record a rectal temperature in a safe manner providing privacy for the client.

PERFORMANCE CRITERIA

The temperature and general condition of the client will be reported to the supervising licensed personnel.

Skill will be performed with 100% accuracy.

Time required to take and record a rectal temperature is 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (container with clean rectal thermometer, container for used thermometers, container for soiled tissues, lubricant, container with tissues, pad and pen, watch with second hand and disposable gloves) go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Raise bed to comfortable working level. Put up opposite side rail. Lower head of bed. Ask client to turn on side. Assist with turning as necessary.
5. Place small amount of lubricant on tissue.
6. Put on gloves. Remove thermometer from container by holding stem end. Read mercury column. Be sure it registers below 96° F. Check condition of thermometer.
7. Apply small amount of lubricant to bulb with tissue.
8. Fold the top bedclothes back to expose anal area.
9. Separate buttocks with one hand. Insert the thermometer gently into rectum 1-1½". Hold in place. Replace bedclothes as soon as thermometer is inserted. Do not leave client unattended.
10. Insert thermometer for five minutes.

11. Remove thermometer, holding by stem. Wipe from stem toward bulb end.
12. Discard tissue in proper container.
13. Read thermometer. Record reading with an "R" to indicate rectal.
14. Wipe lubricant from client. Cleanse anal area. Discard tissue.
15. Remove the materials used in taking the rectal temperature, cleansing the materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
16. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
17. Invite visitors to return to bedside.
18. Report observations to supervising licensed personnel. Observations should include condition of client, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for measuring and recording rectal temperature.

Performance of procedure for selected client.

MEASURE AND RECORD THE BLOOD PRESSURE

Gather, report and record accurate information about client vital signs as directed by the supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

paper	stethoscope
pen	alcohol wipes
blood pressure cuff (sphygmomanometer)	appropriate screening

WORK TO BE PERFORMED

Measure and record blood pressure on the appropriate forms in a safe manner providing for privacy of the client.

PERFORMANCE CRITERIA

Following the gathering and recording of blood pressure, the learner will be able to report findings of client vital signs and general condition to the supervising licensed personnel.

Skill will be performed with 100% accuracy.

Time required to take and record blood pressure is 3-5 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (blood pressure cuff {sphygmomanometer}, stethoscope, paper and pen and alcohol wipes), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Position client comfortably in bed or chair.
5. Place the client's arm palm-upward, supported on bed or table and level with the heart.
6. Roll sleeve of gown up about 5" above elbow. Be sure it is not tight on the arm.
7. Cleanse earpieces and bell of stethoscope.
8. Apply cuff (sphygmomanometer) smoothly and evenly 1-1½" above the elbow. The center of the rubber bladder should be directly over the brachial artery. If the cuff (sphygmomanometer) is marked with an arrow, place cuff (sphygmomanometer) so that arrow points over the brachial artery.
9. Hook cuff (sphygmomanometer) to secure or use Velcro closure. Be sure cuff (sphygmomanometer) is secure but not too tight. Check by slipping two fingers between cuff (sphygmomanometer) and client's arm.
10. Locate the brachial artery with the fingers. The brachial artery is located on the inside of the arm (medial aspect) just inside the elbow.
11. Place earpieces in ears. Place bell of stethoscope directly over the artery.

12. Close valve and reinflate cuff (sphygmomanometer) quickly until gauge registers 180-200 mm Hg.
13. Listen carefully as the valve of bulb is slowly opened and cuff (sphygmomanometer) pressure is released.
14. Allow air to escape slowly (between 1-3 mm per second) until first heart sound is heard. Note reading on gauge as the systolic pressure.
15. Continue to release the air pressure slowly until there is an abrupt change of the sound from very loud to a soft muffled sound. The reading at which this change is heard is the diastolic pressure. Verify what facility policy determines is diastolic pressure.
16. Rapidly deflate cuff (sphygmomanometer) and remove, expel air from the cuff (sphygmomanometer) and replace apparatus. Clean earpieces and bell of stethoscope with antiseptic solution.
17. Wait one minute before repeating this procedure, if repeat pressure is needed.
18. Remove the materials used in recording vital signs, cleansing the materials as necessary prior to storage.
19. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
20. Invite visitors to return to bedside.
21. Report observations to supervising licensed personnel about condition of client, making particular note of any difference in vital sign readings from previous readings or vital signs unable to be recorded for any reason.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for measuring and recording blood pressure.

Performance of procedure for selected client.

MEASURE AND RECORD HEIGHT AND WEIGHT

Gather, report and record accurate information about client vital signs as directed by the supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

- paper
- pen
- portable balance scale
- paper towels
- appropriate screening

WORK TO BE PERFORMED

Measure and record height and weight of the assigned client in a safe manner providing for privacy of the client.

PERFORMANCE CRITERIA

Height and weight will be reported to supervising licensed personnel. The height and weight will be recorded following agency protocol.

Skill will be performed with 100% accuracy.

Time required for measuring and recording the height and weight is 3-5 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (portable balance scale and paper towels), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Have the client urinate prior to measuring weight.
5. Raise height measurement rod.
6. Ask resident to remove robe and slippers or shoes.
7. Assist resident to stand on scale with arms at side of body.
8. Move weights until balance pointer is in the middle of scale indicator.
9. Record client's weight.
10. Have client stand erect.
11. Lower height measurement rod until it rests on head.
12. Record height.
13. Assist the client to put on robe and slippers or shoes or help back to bed.
14. Remove the materials used in measuring height and weight, cleansing the materials as necessary prior to storage.
15. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.

16. Invite visitors to return to bedside.
17. Report observations to supervising licensed personnel including observations about condition of client, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in measuring height and weight.

Performance of procedure for selected client.

MEASURE AND RECORD FLUID INTAKE AND OUTPUT

Gather, report and record accurate information about client vital signs as directed by the supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

paper
pen
intake and output record at bedside
disposable gloves
appropriate screening
separate graduated pitchers for measuring fluid

WORK TO BE PERFORMED

Collect and measure fluid output and/or collect information about and measure fluid intake in a safe and private manner. These measures will be recorded as directed by facility guidelines and tools.

PERFORMANCE CRITERIA

Following recording of measures of intake and output, report to the supervising licensed personnel.

Skill will be performed with 100% accuracy.

Time required to perform this skill will be 5-10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (intake and output record at bedside, separate graduated pitchers for measuring fluid intake and output and disposable gloves), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Explain how the client will assist with accurate recording of intake. If possible, the client will keep a record of the fluids taken by mouth with and between meals.
5. Record intake on the intake/output record at the bedside by listing character and amount of all fluids taken. Total intake includes
   a. Amount of fluid taken with meals;
   b. Amount of fluid taken between meals;
   c. Other fluids taken by mouth, intravenously or by tube feeding.
6. Transfer the information from bedside intake/output record to client's permanent record.
7. Put on disposable gloves to measure fluid output.
8. Take urine collection to bathroom or utility room or if the client is ambulatory, instruct him/her to use the collection device placed in the toilet bowl.
9. Pour urine from bedpan or urinal into graduated pitcher. Measure and record the amount of urine.

10. Record character and amount of urine on the intake/output record. Other forms of output which must be measured and recorded include
    a. Vomitus;
    b. Drainage from a wound or the stomach;
    c. Liquid stool - record an estimated amount;
    d. Blood loss - record estimated amount;
    e. Perspiration - record estimated amount - i.e., degree of linen change needed.
11. Remove the materials used to collect and measure the output, cleansing the materials as necessary prior to storage. Remove and dispose of gloves according to facility policy.
12. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
13. Invite visitors to return to bedside.
14. Report observations to supervising licensed personnel including observations about condition of client, making particular note of character of the output fluids.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in measuring and recording fluid intake and output.

Performance of procedure for selected client.

ASSIST THE CLIENT TO MOVE BETWEEN CHAIR, WHEELCHAIR, BED AND/OR BATHROOM STOOL

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to client needing assistance with transfer between chair, wheelchair, bed and/or bathroom stool and given the following equipment and materials:

paper	shoes
pen	pillow
arm chair	wheelchair
one or two bath blankets	bed
robe	bathroom stool

WORK TO BE PERFORMED

Assist the client to move between chair, wheelchair, bed and/or bathroom stool.

PERFORMANCE CRITERIA

Assistance will be provided without adverse outcome to client and/or learner 100% of the time.

Time required will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (paper, pen, arm chair, one or two bath blankets, robe, shoes, pillow, wheelchair, bed and bathroom stool), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Place chair with back even with headboard. Lock wheels if wheelchair is being used.
5. Place folded bath blanket on seat.
6. Lower bed to lowest horizontal position.
7. Fanfold top linens to foot of bed. Maintain privacy of client as much as possible.
8. Put shoes on client.
9. Help client sit on side of bed:
   a. Help client move to side of bed.
   b. Raise head of bed - protecting the client from falling forward or from the bed.
   c. Lower side rail after head is raised and client is safely positioned.
   d. Slide one arm under client's neck and shoulders. Grasp far shoulder. Place other hand under far knee.
   e. Turn client so that client is upright as legs go over edge of mattress (dangle position).

10. Assist client to put on robe. Use transfer belt control and safety.
11. Assist client to stand:
    a. Stand in front of client.
    b. Place hands under client's arms and around the shoulder blades.
    c. Ask client to push fists into mattress and lean forward on count of three.
    d. Brace learner's knees against client's knees; block client's feet with learner's feet.
    e. Pull client to standing position on count of three.
12. Support client to prevent falling. Keep hands around shoulder blades. Continue to block client's feet.
13. Turn client so that far arm of chair is grasped. Legs will touch edge of chair.
14. Turn client until other armrest is grasped.
15. Lower client into chair as learner bends hips and knees. Client assists by leaning forward and bending elbows and knees.
16. Ensure client's buttocks are to the back of the seat. Position client in good alignment.
17. Place bath blanket over lap and legs.
18. Position client in comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
19. Invite visitors to return to bedside.
20. Report observations to supervising licensed personnel about condition of client, making particular note of skin condition, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for assisting client to transfer.

Performance of procedure for selected client.

USE A TRANSFER (GAIT) BELT TO ASSIST WITH MOVEMENT AND AMBULATION

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client requiring assistance with movement and ambulation and given the following equipment and materials:

paper
pen
robe and slippers
transfer belt
paper or sheet to protect
bottom linens from shoes

WORK TO BE PERFORMED

Use a transfer belt to assist with movement and ambulation.

PERFORMANCE CRITERIA

Determine that client condition allows use of a transfer belt by consulting with supervising licensed personnel.

Provide assistance with movement and ambulation using a transfer belt without adverse outcome to client and/or learner 100% of the time.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (paper, pen, robe and slippers, transfer belt and paper or sheet to protect bottom linens from shoes), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Lock bed wheels; bed is in lowest horizontal position.
5. Fanfold top linens to foot of bed. Maintain privacy of client as much as possible.
6. Put shoes or slippers on client (protect bed linens).
7. Assist client to sit on side of bed (dangle). Help client put on robe.
8. Apply transfer belt:
   a. Apply belt around client's waist over clothing.
   b. Tighten belt so it is snug but not to cause discomfort or interfere with breathing.
   c. Place belt buckle off-center or in back.
9. Assist client to stand:
   a. Stand facing client.
   b. Ask client to place hands on learner's shoulders.
   c. Grasp transfer belt at each side.
   d. Bend at the knees, brace knees against client's knees and block client's feet.
   e. Keep back straight.
   f. Pull client to a standing position as knees are straightened.

10. Stand at client's side while balance is regained. Maintain hold on transfer belt.
11. Assist client to walk. Walk by client's side and support with transfer belt.
12. Walk required and/or tolerated distance.
13. Help client return to bed:
    a. Have client stand at side of bed.
    b. Pivot client a quarter turn so backs of knees touch bed.
    c. Ask client to place hands on learner's shoulders. Grasp sides of transfer belt.
    d. Lower client onto bed as knees are bent. Remove transfer belt and robe.
    e. Help client to lie down.
14. Lower head of bed. Help client to center of bed.
15. Remove slippers or shoes and linen protector, if one is used.
16. Remove the materials used in helping client to ambulate with transfer belt, cleansing the materials as necessary prior to storage.
17. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
18. Report observations to supervising licensed personnel to include observations about condition of client, especially the degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for using transfer (gait) belt.

Performance of procedure for selected client.

PROVIDE ASSISTANCE FOR THE FALLING CLIENT

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to assist a client with ambulation and given the following equipment and materials:

paper	slippers
pen	transfer belt
robe	

WORK TO BE PERFORMED

If the client begins to fall, the learner will be prepared to immediately lower the client to the floor in a safe manner to prevent injury to the client or learner.

PERFORMANCE CRITERIA

Neither the client nor the learner will incur trauma.

Assistance will be provided 100% of the time.

An additional time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Attempt to guide the client to the floor if he/she begins to fall. Keep hold of the transfer belt if one is in place. Explain to the client what to do to help.
2. Maintain a wide base of support and use a "squatting" stance when lowering the client to the floor. The client's head should be protected from hitting the floor. Keep your back straight.
3. Bring client close to your body as quickly as possible.
4. Use transfer belt if one is worn. If no transfer belt, wrap your arms around the client's waist or hold client under the arms.
5. Move your leg so client's buttock rests on it.
6. Lower the client to the floor by allowing the client to slide down your leg. Bend at hips and knees to accomplish this.
7. Stay with the client and call for assistance.
8. Do not move client until examined by supervising licensed personnel. Once it is safe to move the client, return the client to bed.
9. Leave signal cord, telephone and fresh water close at hand. Make sure bed is in lowest position possible. Remove any screening used for privacy.
10. Store any equipment which has been used. Wash hands.
11. Report the incident to supervising licensed personnel. Include the date, time and place of the incident. Provide an objective account of the incident and give client's condition following the return to bed and client's reaction to the incident.
12. Follow agency guidelines for completing an accident report.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for providing assistance to a falling client.

Performance of procedure with another learner.

REPOSITION THE CLIENT IN BED

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

paper	pull sheet
pen	pillow
appropriate screening	small pillow

WORK TO BE PERFORMED

Reposition the client in bed in good body alignment while maintaining client's right to privacy.

PERFORMANCE CRITERIA

Expected outcomes for the client and/or learner will be achieved 100% of the time when repositioning the client in bed.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client.
3. Wash hands.
4. Lock bed wheels; raise bed for good body mechanics.
5. Lower head of bed to a level appropriate for the client. It should be as flat as possible.
6. Go to side of bed opposite that to which you will turn the client. Raise the bed rail which the client will be facing when turned and positioned.
7. Lower side rail near you.
8. Move client to side of bed with side rail near you.
   a. Stand so your feet are about 12" apart and one foot is in front of the other. Flex the knees and hips. Keep back straight.
   b. Cross client's arms over chest, place arm under client's neck and shoulders and grasp far shoulder.
   c. Place other arm under client's midback. Move upper part of client's body toward you.
   d. Put one arm under client's waist and the other under the thighs. Move lower part of client's body toward you by rocking backward.
   e. Repeat actions for legs and feet. Learner's arms should be under client's thighs and calves.
   f. Use of a "pull sheet" is helpful.
9. Cross client's arms over chest. Cross leg near you over other leg.
10. Raise side rail and go to other side. Lower that side rail.

11. Stand with feet 12" apart. Flex the knees and keep back straight.
12. Place one hand on the shoulder of client and the other hand on far hip.
13. Roll client gently toward you.
14. Position client for comfort and good body alignment.
    a. Position pillow against back for support.
    b. Put a pillow under head and shoulder.
    c. Place a pillow in front of bottom leg. Place top leg on pillow in a flexed position.
    d. Support arm and hand with a small pillow.
15. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
16. Invite visitors to return to bedside.
17. Report observations to supervising licensed personnel about condition of client, making particular note of skin condition, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for repositioning the client in bed.

Performance of procedure for selected client.

PERFORM PASSIVE AND ACTIVE RANGE OF MOTION EXERCISES TO UPPER AND LOWER EXTREMITIES

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

paper	appropriate screening
pen	bath blanket

WORK TO BE PERFORMED

Perform active and/or passive range of motion with a client using proper body mechanics in order to protect the client and self while providing for privacy of client.

PERFORMANCE CRITERIA

The entire skill will be accomplished using 3-5 minutes per extremity with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Lock bed wheels and raise bed for good body mechanics.
5. Lower head of bed to a level appropriate for the client. It should be as flat as possible with client in good body alignment.
6. Position client on back close to you. Adjust the bath blanket to keep client covered as much as possible. Repeat each exercise 5-6 times.
7. Supporting the client's elbow and wrist, exercise shoulder joint nearest you. Bring entire arm out at right angle to the body (horizontal abduction). Return arm to a position parallel to the body (horizontal adduction).
8. Roll entire arm toward body with arm parallel to the body (internal rotation of shoulder). Maintain parallel position, roll entire arm away from body (external rotation of shoulder).
9. Flex elbow and raise entire arm over head with shoulder in abduction (shoulder flexion).
10. Flex and extend elbow with arm parallel to body (palm up-supination). Flex and extend elbow.
11. Flex and extend wrist. Flex and extend each finger joint.
12. Move each finger, in turn, away from the middle finger (abduction) and toward the middle finger (adduction).
13. Abduct the thumb by moving it toward the extended fingers.
14. Touch the thumb to the base of the little finger, then to each fingertip (opposition).

15. Turn hand palm down (pronation), then palm up (supination).
16. Grasp client's wrist with one hand and the client's hand with the other. Bring wrist toward body (inversion) and then away from the body (eversion).
17. Point hand in supination toward thumb side (radial deviation) and then toward little finger side (ulnar deviation).
18. Cover the client's upper body and extremities. Move to exercise the lower extremities.
19. Support the knee and ankle. Move the entire leg away from body center (abduction) and toward the body (adduction).
20. Turn to face bed. Support the knee in bent position (flexion). Raise the knee toward the pelvis (hip flexion). Straighten the knee (extension) as the leg is lowered to the bed.
21. Support leg at knee and ankle and roll leg in circular fashion away from body (lateral hip rotation). Continue to support leg and roll leg in same fashion toward the body (medial hip rotation).
22. Grasp client's toes and support ankle. Bring toes toward the knee (dorsiflexion) and then point toes toward end of bed (plantar flexion).
23. Turn client's foot inward gently (inversion) and then outward (eversion).
24. Place fingers over client's toes. Bend toes (flexion) and straighten toes (extension).
25. Move each toe away from the second toe (abduction) and then toward the second toe (adduction).
26. Cover the client with the bath blanket. Move to the other side of the bed and repeat with extremities on opposite side of the body.
27. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
28. Invite visitors to return to bedside.
29. Report observations to supervising licensed personnel to include observations about condition of client, making particular note of skin condition, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for performing passive and active range of motion exercises.

Performance of procedure for selected client.

USE A WHEELCHAIR TO TRANSPORT A CLIENT

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client requiring a wheelchair for transportation and given the following equipment and materials:

paper	chart
pen	appropriate screening
robe/housecoat	transfer belt
wheelchair	bath blanket

WORK TO BE PERFORMED

Transport client in a safe manner observing the client's right to privacy.

PERFORMANCE CRITERIA

Expected outcomes for the client and/or learner will be achieved 100% of the time when a wheelchair is used to transport a client.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (wheelchair, blanket and chart), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client.
3. Wash hands.
4. Position wheelchair near client, lock brakes on wheelchair and raise footrest pedals. Determine if a transfer belt is needed for safe transfer to chair.
5. Assist client into wheelchair. Lower footrest pedals and place client's feet on footrests. Have client sit as far back in the chair as possible.
6. Cover the client's lap and legs with a bath blanket.
7. Secure the client in the wheelchair with a safety belt, if necessary.
8. Release brakes. Push the wheelchair from behind, except when going into and out of elevators.
9. Use the right side of the corridor. Move slowly and look for other traffic especially at doorways or intersections.
10. Transport client to destination and assist client to get out of wheelchair by reversing the procedure for getting into wheelchair.
11. Report observations to supervising licensed personnel to include observations about condition of client, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for transporting client by wheelchair.

Performance of procedure for selected client.

USE A STRETCHER TO TRANSPORT A CLIENT

Use principles of proper body mechanics in providing care and in assisting the client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client requiring transport by stretcher and given the following equipment and materials:

paper	blanket
pen	clean sheet to cover stretcher
stretcher	appropriate screening

WORK TO BE PERFORMED

Transport a client in a safe manner observing the client's right for privacy.

PERFORMANCE CRITERIA

Expected outcomes for the client and/or learner will be achieved 100% of the time when the client is transported by stretcher.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (stretcher, blanket and clean sheet to cover stretcher), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client.
3. Wash hands.
4. Place a clean sheet on the stretcher. Lock the wheels on the bed and stretcher.
5. Fanfold the top bed covers to the bottom or side of the bed. Maintain privacy of the client as much as possible.
6. Move the client from the bed to the stretcher.
7. Position the client on the stretcher in as comfortable a position as possible.
8. Cover the client with a blanket and secure the client on the stretcher with a safety belt.
9. Put side rails in place.
10. Walk at head of stretcher, protecting client's head.
11. Approach corners cautiously, staying on right hand side of corridor.
12. Enter and exit elevators by first securing elevator door. Enter elevator with stretcher head first and exit elevator pushing stretcher foot first.
13. Secure stretcher at destination.
14. Ensure that client is in a comfortable and safe position. Make sure that someone in the receiving unit is aware of client's presence.
15. Report observations to supervising licensed personnel to include observations about condition of client, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for transporting a client by stretcher.

Performance of procedure for selected client.

ADMIT THE CLIENT TO THE UNIT, SERVICE AND/OR FACILITY

Perform nursing care that contributes to maintenance of an accurate data base about the client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is alert and cooperative and given the following equipment and materials:

urine specimen cup	scale
pad	appropriate screening
pen	watch with second hand
client's chart	hospital gown
stethoscope	night clothes from home
admission kit	blood pressure cuff (sphygmomanometer)

WORK TO BE PERFORMED

Gather and report information about the client as directed by the supervising licensed personnel without violating the client's rights.

PERFORMANCE CRITERIA

Data base collection will accurately reflect client condition and be reported immediately.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (for urine specimen, for taking temperature, pad and pen, client's chart or worksheet, stethoscope, admission kit, scale, blood pressure cuff {sphygmomanometer} and watch with second hand), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Introduce the client to other clients in the room unless it is a private room. Explain the signal system and the standard institutional regulations. Explain what will happen in the immediate future, if possible.
5. Help the client to undress and put on a hospital gown or night clothes from home. Care for clothing according to facility policy.
6. Check the client's vital signs, weight and height.
7. Help the client get into bed. Adjust side rails as needed.

8. Document if the client is wearing any jewelry or has valuables that were not left at the cashier's office:
   a. Make a list of them and ask the client to sign it. (This protects the facility and the client.)
   b. Ask the relatives also to sign the list and take the valuables home, or
   c. After checking and signing, put them in the facility safe.
9. Tell the client if a urine specimen is necessary. Assist the client as necessary. Allow client to use the bathroom, if ambulatory, or offer the bedpan or urinal. Put on gloves to handle specimen collection.
10. Pour the specimen from the bedpan into a graduate and then into the specimen bottle. Put on the cap. Be sure to label the specimen correctly. Wash hands.
11. Complete the admission form used by the facility. This usually includes gathering information about
    a. Vital signs (TPR, B/P, height, weight),
    b. Allergies,
    c. Medications being taken,
    d. Food preferences and dislikes,
    e. General observations,
    f. Personal habits.
12. Orient the client to the unit by explaining policies and giving information about
    a. How to operate the bed,
    b. Visiting hours,
    c. How to use phone and/or television and signal light,
    d. TV rental, if available,
    e. Any questions about facility routines,
    f. Time for meals and refreshments,
    g. How to call for personnel.
13. Remove the materials used to admit the client to the unit, cleansing the materials as necessary prior to storage.
14. Place client in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; and remove screening used for privacy.
15. Invite visitors to return to bedside.
16. Report to supervising licensed personnel will include vital signs, height and weight and observations about condition of client, making particular note of skin condition, degree of strength during the procedure and tolerance of the activity.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for admitting client to the facility.

Performance of procedure for selected client.

TRANSFER THE CLIENT BETWEEN UNITS WITHIN THE FACILITY

Perform nursing care that contributes to maintenance of an accurate data base about the client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client needing to be transferred to another unit within the facility and given the following equipment and materials:

client's chart	urinal
nursing care plan	bath basin
medications	emesis basin
plastic bag	robe and slippers
appropriate screening	wheelchair/stretcher
bed pan	

WORK TO BE PERFORMED

Transfer client to another unit within the facility. Observe proper safety guidelines and follow facility guidelines. Communicate necessary information with personnel in the receiving unit/service as directed by the supervising licensed personnel.

PERFORMANCE CRITERIA

Expected outcomes for the client and/or learner will be achieved 100% of the time.

Time will vary according to client condition. The learner will make judgments about client needs which may affect the time required.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Determine the unit to which the client will be transferred. Check to see that it is ready.
2. Receive instructions from the supervising licensed personnel. Gather the equipment needed for the transfer.
3. Assemble equipment (client's chart, nursing care plan, medications and plastic bag), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
4. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
5. Wash hands.
6. Explain transfer protocol to the client.
7. Gather all client's belongings together.
   a. Place all disposables (bed pan, urinal, bath basin and emesis basin) in plastic bag with label to transport with the client.
   b. Check clothing list to ensure clothing is present for transfer.
8. Assist client to put on robe and slippers, if permitted. Assist client into wheelchair or onto stretcher, as directed. Make sure all safety measures are in place.

9. Transport client and belongings to new unit. Use all precautions related to safe transport.
10. Introduce client to staff in new unit. Proceed to client's new room.
11. Give any transferred medications, nursing care plan and chart to supervising licensed personnel in charge.
12. Place client in comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; and wash hands.
13. Report to supervising licensed personnel will include completion of the transfer and observations about condition of client and any problems encountered with the transfer.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for intra-agency transfer of a client.

Performance of procedure for selected client.

COLLECT, REPORT AND RECORD CLIENT DATA ON AN ONGOING BASIS

Perform nursing care that contributes to maintenance of an accurate data base about the client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires care and given the following equipment and materials:

appropriate forms	stethoscope
assignment sheets	sphygmomanometer
pen	thermometer

WORK TO BE PERFORMED

Use assessment skills to collect, report and accurately record client data on all appropriate forms as directed by client condition and specific orders, maintaining confidentiality and not violating client's rights.

PERFORMANCE CRITERIA

Collecting, reporting and recording of client data will ordinarily occur with routine care provided for the client.

The process of reporting and recording data will be determined by institutional protocols. Each learner will be aware of the need for accurate and current information and records and his/her responsibility for confidentiality.

The time required for the interaction should not be more than 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Collect assignment for the period of work. Complete assignment sheets with the required information about each client in a timely manner.
2. Collect, report and record data about how well the client handles the activities of daily living and the particular procedures related to the client's condition. Data will be documented in accordance with the policies of the facility.
3. Collect data about client tolerance for the following activities of daily living:
   a. Vital signs
   b. Nutrition and elimination needs
   c. Mobility/activity needs
   d. Personal hygiene and grooming
   e. Comfort and feeling of satisfaction with status in life
   f. What client says, especially questions about care or a listing of fears he/she expresses
   g. Status of client environment and safety factors
   h. Conditions that raise issues about ability to meet activities of daily living

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in collecting and recording client data.

Performance of procedure for selected client.

DISCHARGE THE CLIENT FROM THE FACILITY

Perform nursing care that contributes to maintenance of an accurate data base about the client as directed by supervising licensed personnel.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

appropriate screening	client's belongings
discharge instructions	medications
valuables list	wheelchair

WORK TO BE PERFORMED

Safely discharge the client within guidelines of the facility.

PERFORMANCE CRITERIA

Expected outcomes for the client will be achieved 100% of the time.

Time will vary according to client condition but should not exceed 15-30 minutes excluding required documentation. The learner will make judgments about client needs which will alter the standard time expected for this level of assistance.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Check to be sure written order for discharge has been completed. Assemble equipment as needed, go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Help the client to dress.
5. Collect the client's personal belongings. Help the client check them against the admission list:
   a. Verify that the client has received discharge instructions from the person responsible.
   b. Pack, if necessary.
   c. Check valuables against list according to facility policy.
   d. Make sure all of the client's belongings have been removed from the closet and bedside stand.
   e. Check to see if medications or other equipment are to go home with the client.
6. Explain to the client or member of the family how to obtain valuables held in the facility safe.
7. Help client into wheelchair.
8. Take client to the discharge entrance of the facility:
   a. Help client to transfer safely into the vehicle.
   b. Be gracious when saying good-bye.

9. Return wheelchair to unit.
10. Wash hands. Complete any recording of discharge required by facility policy.
11. Return to client unit to clean according to facility policy.
12. Report observations to supervising licensed personnel to include observations about condition of client and any unanticipated or untoward events encountered during the discharge.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for discharging client.

Performance of procedure for selected client.

COLLECT A RANDOM URINE SPECIMEN FOR ROUTINE URINALYSIS

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a cooperative client and given the following equipment and materials:

paper/pen
bedpan, urinal or other collection device
urine sample container with lid
label to include client name, location, date and time of collection, physician's name, name of person responsible for the collection and name of test(s) to be performed
graduate pitcher if input/output measures are included in order
biohazard container for specimen transport
completed laboratory requisition slip
disposable gloves

WORK TO BE PERFORMED

Collect, label and transport a urine sample for routine urinalysis in an aseptic manner, as directed by authorized supervising personnel, while protecting client's rights.

PERFORMANCE CRITERIA

Following collection of the urine sample, notify the authorized supervising personnel.

Expected outcomes will be achieved 100% of the time.

In routine circumstances, time to collect the urine sample should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (paper/pen; bedpan, urinal or other collection device; urine sample container with lid; label to include client name, location, date and time of collection, physician's name, name of person responsible for the collection and name of test(s) to be performed; graduate pitcher if input/output measures are included in order; biohazard container for specimen transport; completed laboratory requisition slip; and disposable gloves).

PATIENT PREPARATION

2. Proceed to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using the facility-approved identification system.
3. Explain the collection procedure to the client, family member or care giver. Provide for the client's privacy. Arrange appropriate screening.
4. Wash hands.
5. Put on disposable gloves.

SPECIMEN COLLECTION

6. Instruct the client to void, allowing the first urine to escape, then to collect the continuous midstream portion into a paper cup or other collection device. Pour a 10-15 ml. aliquot into a plastic urine sample tube.
   or
   As a last resort instruct the client to void entire urine volume into a clean urinal, bedpan or other collection device that contains no other organic or biological material. If input/output measurements are ordered, measure and record entire volume. Mix well and pour 10-15 ml. into a plastic urine sample tube. Instruct the client not to put toilet tissue into the urine collection device. Remove and clean any reusable equipment. Dispose of gloves.
7. Apply the completed label to the specimen container.
8. Return client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
9. Invite visitors to return to bedside.

SPECIMEN HANDLING

10. Transport the urine sample immediately to the laboratory in a portable cooler or other device designated for the transport of biohazardous materials.
11. If the urine sample cannot be transported immediately to the laboratory, cool the urine by placing in a cooler, surrounded by ice or a frozen ice gel block or in a refrigerator designated for biological specimens.
12. Report significant observations to authorized supervising personnel, including observations about the condition of the client.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for collecting a random urine specimen for routine analysis.

Identify conditions and disposition of specimens that do not meet the laboratory's criteria for acceptability.

Performance of procedure for selected client.

Identify the specimen of choice for routine urinalysis.

COLLECT URINE FOR CULTURE AND SENSITIVITY

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is able to cooperate and given the following equipment and materials:

sterile urine specimen container
container label with the following information: client's full name, room number, date and time of collection, ordering physician's name, type of specimen and test to be performed
gauze squares or cotton
antiseptic solution
biohazard bag
clean-catch kit
disposable gloves
paper/pen

WORK TO BE PERFORMED

Under the supervision of authorized personnel, collect, label, store and transport a urine for culture and sensitivity in a safe manner while protecting the client's rights.

PERFORMANCE CRITERIA

Following collection of the urine specimen, notify the supervising licensed personnel of any difficulty in completing the collection.

Skill will be performed with 100% accuracy.

Time to collect a clean-catch urine specimen for culture will vary according to client condition but should not exceed 10 minutes excluding time for documentation.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (sterile urine specimen container; container label with the following imformation: client's full name, room number, date and time of collection, ordering physician's name, type of specimen and test to be performed; gauze squares or cotton; antiseptic solution; biohazard bag; clean-catch kit; disposable gloves; and paper/pen).

PATIENT PREPARATION

2. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification. Explain the procedure to the client, family member or care giver. A urine specimen should be collected prior to beginning antibiotic therapy. In the event that antibiotics have been started or just completed, list these antibiotics on the laboratory request form. Arrange for privacy of the client.
3. Wash hands.
4. Put on disposable gloves.

SPECIMEN COLLECTION

5. For the female client:
   a. Remove the client's underclothing and have her sit comfortably on the toilet seat, swinging one knee to the side as far as possible.
   b. Using a forward to back motion, cleanse the periurethral area and the perineum with two to three gauze pads saturated with soap as provided with the clean catch kit. Rinse with sterile saline or water.
   c. During the voiding, hold the labia apart.
   d. Allow the first few milliliters of urine to pass into the toilet or bed pan to flush out bacteria from the urethra.
   e. Collect the midstream portion of urine in a sterile, wide mouthed container that can be covered with a tightly fitted lid.

   For the male client:
   a. Expose the client's penis.
   b. Cleanse the urethral meatus immediately before voiding.
   c. Allow the first few milliliters of urine to pass into the toilet or bed pan to flush out bacteria from the urethra.
   d. Collect the midstream portion of urine in a sterile, wide mouth container that can be covered with a tightly fitted lid.
6. Remove the materials used in collecting the clean-catch urine specimen. Dispose of items according to facility protocol. Cleanse any reusable items prior to storage. Remove and dispose of gloves according to facility policy. Wash hands. If client has been responsible for cleansing and collecting the specimen, provide hand washing materials to the client.
7. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; and remove soiled linens. Wash hands.
8. Invite visitors to return to bedside.
9. Report observations to supervising licensed personnel to include the condition of the client, degree of strength during the procedure and tolerance of the activity.

SPECIMEN HANDLING

10. Attach a completed label to the capped, sterile urine container.
11. Place the container in the cooler for immediate transport to the laboratory within 30 minutes of collection.
12. If the urine cannot be brought to the laboratory immediately, place a frozen gel coolant around the specimen. DO NOT STORE THE URINE SPECIMEN IN A REFRIGERATOR ALONG WITH FOOD OR MEDICATION. STORE SPECIMENS ONLY IN UNITS THAT ARE DESIGNATED SPECIFICALLY TO HOLD BIOLOGICAL SPECIMENS.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in collecting a clean-catch urine specimen for culture and sensitivity.

Performance of collection procedure for selected client.

Identify conditions and the disposition of specimens that do not meet the laboratory's criteria for acceptability.

COLLECT A TIMED (24, 12, 6, 4, 2 HOUR) URINE SPECIMEN

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is able to cooperate and given the following equipment and materials:

system with biohazard labels for keeping collected urine cool such as a styrofoam container with frozen gel bricks or ice
adequate urine container labelled with any required preservatives for collecting urine
paper/pen
sign for client's bed indicating procedure is in progress
disposable gloves
completed label

WORK TO BE PERFORMED

Collect an accurately timed urine specimen for quantitative analysis (such as a creatinine clearance or total protein) in an aseptic manner, ensuring client rights are protected. Write client height and weight on the laboratory slip. Coordinate collection with the laboratory personnel to ensure the proper preservative, if required, is added to the urine collection system and to ensure that accurately timed corresponding blood specimens are collected.

PERFORMANCE CRITERIA

During and following the timed urine collection, notify the supervising licensed personnel of any difficulty in completing the collection.

Expected outcomes for the client will be achieved 100% of the time.

An additional time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (system with biohazard labels for keeping collected urine cool such as a styrofoam container with frozen gel bricks or ice; an adequate urine container labelled with any required preservatives for collecting urine; paper/pen; sign for client's bed indicating procedure is in progress; disposable gloves; and a completed label).

PATIENT PREPARATION

2. Go to client's room, knock, introduce self, identify the client by checking arm bracelet or using facility-approved identification system. Explain the procedure to the client, family member or care giver. Emphasize to the client the necessity of saving all urine passed during the collection period. Provide for the client's privacy, arranging appropriate screening. When a blood specimen is required as part of the procedure, as in the case of the creatinine clearance, advise the client that blood will be drawn.

3. **Label the container with the client's name, identification number as required, location, date, ordering physician's name, test ordered, type of specimen, name of person responsible for the collection, time collection started and time collection ended.**
4. Place a sign on the client's bed noting the beginning of the timed urine collection. A sign noting the collection period may also be placed in the bathroom as a client reminder.
5. Wash hands.
6. Put on the disposable gloves.
7. Request the client to void, assisting as needed. If output is monitored, measure and record the amount of urine passed; **discard this specimen**; note the time of voiding. THE TIMING FOR COLLECTION BEGINS NOW.
8. Take off gloves and wash hands.

SPECIMEN COLLECTION AND HANDLING

9. Putting on gloves for each event, collect all urine and add to cooled specimen container for the designated time interval. Take off gloves and wash hands.
10. At the end of the collection period, put on gloves, ask the client to void one last time adding this urine to the container. Note the time of this last voiding.
11. Remove, clean and/or dispose of equipment used for collecting the timed urine specimen. Store reusable items. Remove gloves and wash hands.
12. Restore the client to comfortable and safe position, leaving the bed in the lowest position; leave signal cord, telephone and fresh water close at hand; remove any privacy screening; remove soiled linens. Wash hands.
13. Thank client for cooperation. Remove sign from client's bed. Check container label for accuracy and completeness. Attach the appropriate laboratory requisition with any observations regarding the condition of the client and accuracy and completeness of the timed urine collection. Arrange for immediate transport of the urine specimen to the laboratory.
14. Invite visitors to return to bedside.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for collecting a timed urine specimen.

Demonstrate collection procedure for selected client, including recording times and volumes.

Identify conditions and disposition of specimens that do not meet the laboratory's criteria for acceptability.

COLLECT A FECAL (STOOL) SPECIMEN

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is able to cooperate and given the following equipment and materials:

- label to include client name, location, date and time of collection, ordering physician's name, name of person responsible for the collection, name of test(s) such as ova and parasites, culture and sensitivity to be performed
- biohazard container for specimen transport
- tongue blades and/or commercially prepared collection system
- bedpan and cover
- specimen container
- completed laboratory requisition
- disposable gloves
- paper/pen

WORK TO BE PERFORMED

Collect, label and transport a stool sample, as directed by the supervising licensed personnel, in a safe manner while providing privacy and protecting the client's rights.

PERFORMANCE CRITERIA

Following collection of the fecal sample, notify the supervising licensed personnel of any difficulty or unusual observation encountered in obtaining specimen.

Skill will be performed with 100% accuracy.

Time to collect the stool specimen will vary according to client condition but should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (label to include client name, location, date and time of collection, ordering physician's name, name of person responsible for the collection and name of test(s) such as ova and parasites, and culture and sensitivity to be performed; biohazard container for specimen transport; tongue blades and/or commercially prepared collection system; bedpan and cover; specimen container; completed laboratory requisition; disposable gloves; and paper/pen).

PATIENT PREPARATION

2. Proceed to client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved identification system.
3. Explain the collection procedure to the client, family member or care giver. Provide for the client's privacy. Arrange appropriate screening.
4. Wash hands.
5. Put on disposable gloves.

SPECIMEN COLLECTION

6. Ask the client to defecate into a clean, dry bedpan or diaper. Do not contaminate the specimen with urine or toilet tissue.

SPECIMEN HANDLING

7. Use tongue blades or the collection spoon built into the lids of the commercially prepared kit to remove a representative specimen from the bedpan or other collection device. If a portion of the specimen is bloody, purulent, slimy or watery appearing, select the sample from this material. Place the selected sample into the specimen container(s) without contaminating the outside of the container. When the collection requires preservative, mix the contents of the tube with the specimen, cap the container and shake vigorously.
8. Attach the completed label.
9. Place the specimen(s) in a plastic bag for the transport of biohazardous materials. Transport to the laboratory immediately.
10. Remove and clean reusable equipment soiled in collecting the fecal specimen.
11. Wash hands thoroughly after degloving.
12. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest, safe position; remove screening used for privacy; remove soiled linens; and wash hands.
13. Invite visitors to return to bedside.
14. Report completion of the fecal specimen collection to the supervising licensed personnel. Include any observation about the condition of the client and/or the stool specimen.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for collecting stool specimens.

Performance of procedure for selected client.

Identify conditions and disposition of specimens that do not meet the laboratory's criteria for acceptability.

COLLECT A SPUTUM SPECIMEN

Patient test management.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is able to cooperate and given the following equipment and materials:

- sterile specimen container
- label including client's name, location, ordering physician, date and time of collection, test ordered, type of specimen and name of person responsible for the collection
- tissue to cover client's mouth during coughing
- antibiotic therapy, if any
- paper/pen
- disposable gloves
- emesis basin
- water for gargling

WORK TO BE PERFORMED

Collect, label and transport a sputum specimen in a safe manner under the direction of the supervising licensed personnel while protecting the client's rights.

PERFORMANCE CRITERIA

Following collection of sputum specimen, notify the supervising licensed personnel of any difficulty in completing the collection.

Skill will be performed with 100% accuracy.

Time will vary according to client condition. Sputum collection should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (sterile specimen container; label including client's name, location, ordering physician, date and time of collection, test ordered, type of specimen and name of person responsible for the collection; water for gargling; tissue to cover client's mouth during coughing; antibiotic therapy, if any; paper/pen; disposable gloves and emesis basin).

PATIENT PREPARATION

2. Go to client's room, knock, introduce self, identify the client by checking the arm bracelet or using facility-approved identification system. Explain the procedure to the client, family member or care giver. An early morning sputum sample contains pooled overnight secretions and is the specimen of choice. Provide for privacy of the client.
3. Wash hands.
4. Put on disposable gloves.
5. Ask the client to gargle with water to reduce the number of contaminating oropharyngeal bacteria. Use emesis basin for waste.

SPECIMEN COLLECTION

6. Ask client to take a deep breath and to cough deeply to bring up sputum. Expectorate into the labelled container.
   a. Have client cover mouth with tissue during deep coughing to prevent spread of infection.
   b. Collect 1-2 tablespoons of sputum into the labelled container unless otherwise ordered.
   c. Do not touch the outside of the container. Put lid onto the container immediately.

SPECIMEN HANDLING

7. Decontaminate any non-disposable equipment used in the collection of the sputum specimen. Dispose of unrecyclable wastes including gloves and wash hands.
8. Restore client to a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
9. Invite visitors to return to bedside.
10. Report and record completion of sputum collection to supervising licensed personnel. Include any observations about client condition or sputum collected.
11. Transport the sputum specimen in a biohazard bag or container to the laboratory.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for collecting sputum specimens.

Performance of collection procedure for selected client.

Identify conditions and disposition of specimens that do not meet the laboratory's criteria for acceptability.

COLLECT A WOUND DRAINAGE SPECIMEN

(Licensed Practical or Registered Nurse)

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with a draining wound and given the following equipment and materials:

paper	completed label
pen	appropriate screening
sterile gloves	disposable gloves
sterile swabs	biohazard container
specimen tube	sterile specimen container

WORK TO BE PERFORMED

Collect a wound drainage specimen for routine analysis in an aseptic manner without violating the client's rights to privacy.

PERFORMANCE CRITERIA

Principles of asepsis will be used in providing wound care and collection of the wound drainage specimen.

Collection of a wound drainage specimen is ordinarily in conjunction with routine wound care and dressing change. Time for that care will vary dependent upon condition of the wound but should not exceed 10 minutes, excluding time for required documentation.

Following collection of the wound drainage specimen for routine analysis, follow supervisory direction for delivery of the specimen for analysis.

Skill will be performed with 100% accuracy.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (materials to change the dressing; sterile gloves; sterile swabs; specimen tube; and label for container with client's full name, room number, date and time of collection, physician's name and type of specimen/test to be performed), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or use facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain the procedure to the client, family member or caregiver.
3. Wash hands.
4. Put on disposable gloves to remove the soiled/old dressing. Have biohazard container ready. Follow instructions for dressing changes to dispose of soiled/old dressing.
5. Dispose of old dressing and gloves together in biohazard bag. Open materials to collect sterile specimen. Don sterile gloves.

6. Open the sterile specimen container, being careful not to contaminate the inside of the container. Use sterile swab to collect drainage from the site, absorbing as much drainage as possible onto the swab. Collect from the site of heaviest drainage. Place swab in the sterile specimen container. Use additional swabs and specimen container to collect from distinct drainage sites.
7. Use one swab for one wipe of the drainage site. Each swab should be in a separate specimen container. Care is taken not to contaminate the outside of the specimen container.
8. Finish cleansing the wound and changing the dressing using sterile technique.
9. Dispose of materials used to change the dressing and collect the specimen in accord with facility protocol. Cleanse any reusable items used in changing dressing and collecting a wound drainage specimen prior to storage. Remove and dispose of gloves according to facility policy. Wash hands.
10. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
11. Invite visitors to return to bedside.
12. Report and record observations to supervising licensed personnel. Observations should include characteristics of drainage, status of the wound and dressing change.
13. Send labelled specimen for analysis according to facility policy.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for collecting a wound drainage specimen.

Performance of procedure for selected client.

TEST BLOOD SUGAR (FINGER-STICK METHOD)

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is able to cooperate and given the following equipment and materials:

- paper
- pen
- appropriate screening
- disposable gloves
- blood glucose monitoring device
- antiseptic wipes
- disposable gloves
- lancet
- Band-Aid
- glucose oxidase strips

WORK TO BE PERFORMED

Collect and test routine specimens as directed by supervising licensed personnel; test blood sugar (finger-stick method).

PERFORMANCE CRITERIA

Following collection and testing of blood for sugar level, notify the supervising licensed personnel of the blood sugar level.

Time for testing blood sugar using finger-stick method will vary according to client condition but should not exceed 10 minutes.

Skill will be performed with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble the equipment (blood glucose monitoring device, antiseptic wipes, disposable gloves, lancet, Band-Aid and glucose oxidase strips), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or use facility-approved and accepted method of identification. Make sure manufacturer's instructions are followed.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Put on disposable gloves.
5. Perform control to ensure value is within accepted range. If yes, proceed. If no, notify supervising licensed personnel.
6. Cleanse the client's finger, using a disposable antiseptic wipe. Allow the site to dry.
7. Using a lancet, either alone or as part of a holding device, prick the side of the finger to obtain a drop of blood.
8. Make proper use of the equipment provided in the facility to collect and test the blood.
9. Wipe the client's finger with an antiseptic wipe. Provide a Band-Aid for application to the finger-stick site.

10. Remove the materials used in collecting the specimen, cleansing any materials as needed prior to storage. Remove and dispose of gloves according to facility policy. Wash hands.
11. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and remove soiled linens.
12. Invite visitors to return to bedside.
13. Report results to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for testing blood sugar.

Performance of procedure for selected client.

PREPARE CLIENT FOR SURGERY

(Registered Nurse)

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who is to have surgery and given the following equipment and materials:

- thermometer
- stethoscope
- sphygmomanometer
- watch with second hand
- flashlight
- spirometer
- hospital gown
- correct forms
- pen

WORK TO BE PERFORMED

Assess and document readiness of client status for surgery following the direction of supervising licensed personnel without violating the client's rights.

PERFORMANCE CRITERIA

Report assessment findings to the supervising licensed personnel immediately following assessment and preparation of the client for surgery.

Skill will be performed with 100% accuracy.

Time to prepare a client for surgery will vary according to client condition. A time limit is not assigned to this skill standard statement.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Systematically identify and correct problems before surgery and establish a baseline for post-operative comparison. Assessment of client status:
   a. Cardiovascular system - standard expectations for assessment of cardiovascular system function including radial and pedal pulses and standard vital signs.
   b. Chest and lungs - standard expectations for assessment of the respiratory system function including appearance of chest, breath sounds, signs of tissue oxygenation and any smoking or chronic respiratory system problems.
   c. Gastrointestinal system - standard expectations for assessment of the gastrointestinal system function including contour and symmetry, bowel sounds, palpation for tenderness or distention, elimination, intake and output.
   d. Genitourinary system - standard expectations for assessment of the genitourinary system function including palpation of bladder, review and interpretation of laboratory studies, assessment of drainage devices, review and interpretation of intake and output.

e. Neurologic system - standard expectations for assessment of the neurologic system function including level of consciousness (orientation to person, place and time), pupillary size and reaction, gross motor activity, fine motor function, communication ability and coordination.
f. Psychological status - standard expectations for assessment of psychological status including evidence of anxiety, inappropriate behavior, evidence of past psychologic stress and degree of support system.

2. Teach client about surgery by including information about pre-operative needs and preparation, intra-operative experiences and post-operative status and expectations.
   a. Review physician's orders and client's chart.
   b. Discuss the surgery and answer client questions about the surgery.
   c. Explain use of drains and drainage systems as necessary.
   d. Explain consent forms.
   e. Explain the processes client will encounter through the operative experience.
   f. Teach client to turn, deep breathe and cough, exercise and ambulate.
   g. Explain reasons and use of spirometry.
   h. Explain dietary and intake restrictions, pre-operative and post-operative.
   i. Explain surgical prep, enema and catheterization as prescribed.
   j. Explain procedures for safeguarding personal possessions.
   k. Instruct client to wear hospital gown and to empty bladder prior to receiving pre-operative medication.
3. Document assessment findings and pre-operative teaching in accord with facility guidelines.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation in preparing client for surgery.

Performance of procedure for selected client.

Accurate documentation of client care in accord with facility guidelines.

Report of findings to supervising licensed personnel.

PROVIDE POST-OPERATIVE CARE

(Licensed Practical or Registered Nurse)

Provide post-operative care for client received on post-operative medical-surgical care unit.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client in a post-operative medical-surgical care unit in stable post-operative condition and given the following equipment and materials:

- proper forms
- pen
- thermometer
- stethoscope
- sphygmomanometer
- flashlight
- watch with second hand
- any equipment specific to surgical procedures

WORK TO BE PERFORMED

Monitor condition, provide care in accord with facility guidelines and physician orders and communicate condition of client to supervising licensed personnel.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

A time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assessment of client status will include checking vital signs: patent airway, evaluation of level of consciousness, respiratory rate, rhythm and depth, B/P, all pulses and evaluation of any cyanosis.
2. Assess skin: warmth, temperature and color.
3. Assess intravenous infusion: type/rate of infusion, appearance of infusion site, adequacy and safety of covering/dressing.
4. Examine and record the surgical wound: location, characteristics, type of dressing, quantity and type of drainage, presence and type of any drainage device, type of wound closure if evident.
5. Assess and record the abdomen: bowel sounds, presence of nasogastric tube and character of drainage. If necessary, confirm location in stomach.
6. Assess comfort level: assess comfort of client including verbal as well as non-verbal evidence of discomfort. Ensure that any attachments such as hardware, drainage devices, catheters and dressings are functioning as intended. Position as necessary to promote comfort. Provide medication as needed in accord with physician orders.
7. Record intake and output as directed by supervising licensed personnel and as dictated by client condition.

8. Anticipate, record and report post-operative complications including:
   a. Hypovolemia - decrease in circulating blood - may result from blood loss, severe dehydration, third-space sequestration or abnormal fluid loss.
   b. Septicemia and septic shock - severe systemic infection - may result from break in asepsis during operative periods or from peritonitis.
   c. Atelectasis and pneumonia - incomplete lung expansion - may result from hypoventilation and/or retained secretions.
   d. Thrombophlebitis and pulmonary embolism - immobility during the operative period predisposes to venous stasis - a precursor to thrombophlebitis.
   e. Urine retention - inability to spontaneously urinate following surgery in the absence of any obstruction.
   f. Wound infection, dehiscence and evisceration.
   g. Abdominal distention, paralytic ileus and constipation - sluggish peristalsis and paralytic ileus usually follow surgery for 24-72 hours.
   h. Altered body image.
   i. Post-operative psychosis - may result from cerebral anoxia, fluid and electrolyte imbalance, malnutrition and drugs - may result from fear, pain and disorientation.
9. Take actions to reduce the occurrence of post-operative complications:
   a. Turn and reposition the client at intervals directed by protocols or as directed by the physician - promotes circulation, reduces risk of skin breakdown.
   b. Encourage coughing and deep breathing (including use of the spirometry) - promotes lung expansion, enhances oxygenation, lowers risk of secretion buildup in airways.
   c. Monitor nutrition and fluid balance - essential to maintain tissue integrity, to promote healing of surgical wound and to provide energy for the healing process.
   d. Promote exercise and ambulation including early and progressive stages of ambulation in accord with care protocols and range of motion exercises.
   e. Monitor surgical dressing, mark outlines of visible drainage, record date and time and maintain patency of drains.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for administering post-operative care.

Performance of procedure for selected client.

Accurate documentation of client care in accord with facility guidelines.

Report of findings to supervising licensed personnel.

ADMINISTER OXYGEN BY MASK AND BY CANNULA

(Licensed Practical or Registered Nurse)

Perform nursing care that will contribute to and support the client in maintaining tissue oxygenation sufficient to meet activities of daily living at the level defined by client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires assistance to maintain tissue oxygenation and given the following equipment and materials:

proper forms	"oxygen precautions" sign
pen	oxygen
appropriate screening	cannula
equipment for oxygen administration	mask

WORK TO BE PERFORMED

Administer oxygen in accord with prescription and institutional protocol.

PERFORMANCE CRITERIA

Expected outcomes for the client will be achieved 100% of the time.

Physical care requires a minimum of 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble the necessary equipment for oxygen administration, check the order, go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Instruct the client, roommates and visitors about safe administration of oxygen: no smoking is allowed in presence of oxygen administration and all electrical appliances should be properly grounded. A sign indicating need for "oxygen precautions" is prominently displayed outside the room and inside the room.
5. Assess the client with particular emphasis on cardiopulmonary assessment and any signs of hypoxia.
6. Assemble necessary equipment for type of administration and initiate the oxygen administration:
   a. Cannula
      (1) Check for oxygen flow before placing prongs.
      (2) Direct the curved prongs inward, following the nostrils' natural curve.
      (3) Hook the tubing behind the ear and under the chin.
      (4) Set the flow rate, as ordered.
      (5) Tape or pin the connecting tubing to client's clothing or gown.
      (6) Make sure there are no kinks in tubing.

b. Mask
   (1) Make sure flow rate is at least 5 liters/minute (or as directed by facility policy). Low flow rates do not flush carbon dioxide from the mask and can be dangerous.
   (2) Position the mask over the client's nose, mouth and chin. Fasten the strings to hold the mask in place. Shape the metal piece over the bridge of the nose.
   (3) Use padding as necessary to aid comfort and fit of mask.

7. Monitor oxygen administration:
   a. Cardiopulmonary assessment with particular emphasis on detecting signs of hypoxia including decreased level of consciousness, tachycardia, arrhythmias, diaphoresis, restlessness, altered blood pressure or respiratory rate, clammy skin and cyanosis.
   b. Follow principles of caring for person in recumbent state: assessment of skin integrity, frequent administration of skin care and change position as needed. Clients with oxygen administration should have head of bed elevated unless contraindicated.
   c. Assess skin affected by equipment used to administer oxygen: skin on face, nose, chin and ears.
   d. Give oral hygiene as directed.
   e. Assure equipment is functioning appropriately. Follow instructions and protocol of the facility.
8. Ensure the client is in a safe and comfortable position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
9. Invite visitors to return to bedside.
10. Report completion of procedure to supervising licensed personnel. Report and record assessment findings according to facility protocol.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for administering oxygen.

Performance of procedure for selected client.

ASSIST CLIENT TO TURN, COUGH AND DEEP BREATHE

(Licensed Practical or Registered Nurse)

Perform nursing care that will contribute to and support the client in maintaining tissue oxygenation sufficient to meet activities of daily living at the level defined by client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires assistance to maintain tissue oxygenation and given the following equipment and materials:

appropriate screening
pillow
folded bath blanket

WORK TO BE PERFORMED

Assist the client to turn, cough and deep breathe in a safe manner as needed or as prescribed by physician and/or by institutional protocols maintaining the client's right to privacy.

PERFORMANCE CRITERIA

Expected outcomes for the client will be achieved 100% of the time.

Time will vary according to client condition but should not exceed 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble any equipment needed to assist with coughing and deep breathing, go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Process to be used.
   a. Instruct client in coughing exercise:
      (1) A pillow, folded bath blanket or the client's hands should be used to splint and support any surgical incision which may be present.
      (2) If condition permits, position client in a sitting position or on the side of the bed with feet supported.
      (3) Instruct the client to take a slow deep breath, breathing in through the nose and concentrating on fully expanding the chest. The client should breathe out through the mouth, concentrating on feeling the chest move downward and inward.
      (4) A second breath is taken in the same fashion. On the third breath, the client is instructed to hold the breath, then cough two to three times in a row.
      (5) The client should concentrate on feeling the diaphragm move air from the chest. The client should then take five breaths and relax.
      (6) This process should be repeated at least one time. Deep breathing and coughing should be encouraged for all clients with decreased level of activity and will be prescribed in particular instances.

b. Instruct client to deep breathe:
   (1) The client should be instructed to use the diaphragm and abdominal muscles, not those of the chest. Deep breathing can be performed in lying, standing and/or sitting position.
   (2) Place a hand on the chest and on the upper abdomen. Movement can be detected and monitored in this manner.
   (3) The client should exhale normally. The client should then inhale deeply through the nose, concentrating on feeling the abdomen rise; the chest should not expand. This breath is held for a count of five. Then the client will exhale through pursed lips.
   (4) This exercise is repeated 5-10 times.

c. Turn and position:
   (1) Follow the principles outlined in "Use principles of proper body mechanics in providing care and in assisting the client: Reposition the client in bed."

5. Ensure client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
6. Invite visitors to return to bedside.
7. Report observations to supervising licensed personnel including client tolerance for the activity and any unanticipated results.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for assisting client to turn, cough and deep breathe.

Performance of procedure for selected client.

PERFORM ORAL SUCTIONING

(Licensed Practical or Registered Nurse)

Perform nursing care that will contribute to and support the client in maintaining tissue oxygenation sufficient to meet activities of daily living at the level defined by client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires assistance to maintain tissue oxygenation and given the following equipment and materials:

- paper
- pen
- suction machine
- suction catheter
- sterile gloves
- sterile solution
- container for sterile solution
- towel
- appropriate screening
- moisture-proof disposal receptacle

WORK TO BE PERFORMED

Suction the client's oral cavity in an aseptic manner without violating client's right to privacy.

PERFORMANCE CRITERIA

Expected outcomes for the client will be achieved 100% of the time.

Time will vary according to client condition and tolerance of the procedure but should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (suction machine, suction catheter, sterile gloves, container for sterile solution, sterile solution, moisture-proof disposal receptacle and towel), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening.
3. Explain to the client what is to be done and how he/she can assist with the process. Position the client in a sitting position if possible.
4. Wash hands.
5. Place the towel over the client's chest and under the chin. Open the equipment maintaining sterility of contents. Pour sterile saline into sterile basin being careful to maintain sterility of basin and contents.
6. Put on the gloves in a sterile fashion. One glove will remain sterile throughout the procedure; one glove will be contaminated as suction is controlled.
7. Test the adequacy of suction by inserting the catheter into the sterile solution; this also will lubricate the suction catheter.
8. Estimate length of catheter needed to reach the pharyngeal region. Insert the suction catheter into the oral cavity without applying suction. (This eases movement of the catheter through the mouth and diminishes chance of trauma to mucosa.)

9. Apply intermittent (no longer than 5-10 seconds) suction when the pharyngeal region is reached. Remove the catheter from the oral/pharyngeal region, cleansing with sterile gauze if secretions are thick and cleansing the catheter by suctioning solution through the catheter.
10. Repeat the above process to clear the passages, encouraging the client to breathe deeply and cough between suctions.
11. Do not suction for longer periods than 5-10 minutes. (Longer periods of suctioning tend to decrease the client's oxygen supply.)
12. Evaluate the adequacy of the suctioning process. Assess quality of air flow into and out of respiratory tract.
13. Remove the materials used in suctioning when finished, cleansing any materials as necessary prior to storage. Remove and dispose of materials according to facility policy.
14. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove screening used for privacy; remove soiled linens; and wash hands.
15. Invite visitors to return to bedside.
16. Report results of suctioning to supervising licensed personnel, including character of secretions removed with suctioning and client's tolerance of the procedure.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for performing oral suctioning.

Performance of procedure for selected client.

ASSIST WITH USE OF INCENTIVE SPIROMETRY

(Licensed Practical or Registered Nurse)

Perform nursing care that will contribute to and support the client in maintaining tissue oxygenation sufficient to meet activities of daily living at the level defined by client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires assistance to maintain tissue oxygenation and given the following equipment and materials:

pen	appropriate screening
stated goals for client	incentive spirometry

WORK TO BE PERFORMED

Provide assistance with safe use of incentive spirometry while maintaining client's right to privacy.

PERFORMANCE CRITERIA

Expected outcomes for the client will be achieved 100% of the time.

Time will vary according to client condition but should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Verify presence of equipment at the bedside, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening.
3. Explain incentive spirometry to the client, family member or caregiver. Follow facility policy and guidelines explaining the device. The client is encouraged to use the device at least five times per day.
4. Wash hands.
5. Verify goals are correct for client.
6. Observe the client as the spirometry is used to encourage inspiratory sufficiency.
7. Clean and store the spirometer upon completion of treatment following facility policy.
8. Restore the client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
9. Report use of the spirometry and client's ability to achieve goal levels to the supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for use of incentive spirometry.

Performance of procedure for selected client.

PROVIDE TRACHEOSTOMY CARE

(Licensed Practical or Registered Nurse)

Perform nursing care that will contribute to and support the client in maintaining tissue oxygenation sufficient to meet activities of daily living at the level defined by client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires assistance to maintain tissue oxygenation and given the following equipment and materials:

pen	sterile suction catheter
paper	sterile saline solution
hydrogen peroxide	syringe and normal saline
bowl for cleansing	sterile gloves
sterile water	moisture-resistant bag
brush or swab	sterile towel
suction equipment	oxygen source

WORK TO BE PERFORMED

Perform tracheostomy care in an aseptic manner in accord with prescription and institutional protocol.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time will vary according to client condition but should not exceed 30 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (hydrogen peroxide, bowl for cleansing, sterile water, brush or swab for cleansing, suction equipment, sterile suction catheter, container with sterile saline solution, syringe and normal saline, sterile gloves, moisture-resistant bag, sterile towel and oxygen source) or use sterile kit provided by facility, go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide privacy for the client. Arrange appropriate screening. Explain the procedure to client, family member or caregiver.
3. Wash hands. Suction the tracheotomy as necessary prior to care.
4. Clean the cannula.
   a. Use sterile field with sterile technique.
   b. Open bowl to be used for cleansing the cannula. Pour in sufficient hydrogen peroxide to soak cannula. Prepare the brush or swabs to be used for cleansing.
   c. Prepare sterile bowl with sterile solution to rinse inner cannula.
   d. Remove inner cannula from the outer tube and place in the peroxide.
   e. Put on the sterile gloves and use the brush or swabs to cleanse the inner cannula. Rinse with sterile normal saline or sterile water. Shake off excess rinse solution. Replace in the outer cannula.

5. Cleanse skin around the tracheotomy stoma, making sure the solution does not enter the stoma. (It can cause mucosal irritation or be aspirated into the respiratory tract.) Do not use cotton or materials that are easily frayed.
6. Follow principles for intratracheal suctioning:
   a. Follow agency protocol about hyperventilation prior to suctioning.
   b. Sterile procedure requires sterile equipment and process.
   c. Moisten catheter prior to insertion in stoma. Suction rinse solution through catheter to make sure it is working properly.
   d. Assess for adequacy of ventilation prior to initiating suctioning and during the process.
   e. Do not suction while catheter is being inserted. This causes mucosal damage and removes oxygen.
   f. Apply suction for 5-10 seconds only. Then remove the catheter.
   g. Allow 5-10 breaths between catheter insertion.
   h. Repeat suctioning until passage is clear. Try to clear in five passes of the catheter.
7. Assess for adequacy of ventilation by listening to air passage and auscultation of the chest.
8. Replace old or soiled tapes holding outer cannula in place.
9. Remove the materials used for intratracheal suctioning and tracheostomy care, cleansing materials as necessary prior to storage. Remove and dispose of gloves and suctioning items according to facility policy.
10. Ensure that client is comfortable and in a safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove any soiled linens; and wash hands.
11. Invite visitors to return to bedside.
12. Report completion of procedure to supervising licensed personnel. Include observations of sputum characteristics, tolerance of procedure and characteristics of stoma and surrounding skin.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for providing tracheostomy care.

Performance of procedure for selected client.

MEASURE OXYGEN SATURATION WITH PULSE OXIMETER

(Licensed Practical or Registered Nurse)

Perform nursing care that will contribute to and support the client in maintaining tissue oxygenation sufficient to meet activities of daily living at the level defined by client.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires assistance to maintain tissue and given the following equipment and materials:

appropriate screening
appropriate forms
pulse ovimeter

WORK TO BE PERFORMED

Measure arterial oxygen saturation using oximetry methods in accord with prescription and institutional protocol.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Evaluation of oximetry levels should not exceed 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Evaluate for presence of any factors which could interfere with accuracy of reading of arterial oxygen saturation levels including degree of light, client movement, temperature, blood pressure level and vasoconstriction and nail polish.
5. Read the monitor recording of oxygen saturation levels.
6. Protect the transducer from strong light. Check the skin with monitor placement for abrasion and vascular insufficiency. Compare pulse reading and client's actual pulse and report any discrepancies.
7. Assess for adequacy of placement. Rotate the transducer every four hours to discourage skin impairment.
8. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; remove soiled linens; and wash hands.
9. Invite visitors to return to bedside.
10. Report readings as required by agency protocol.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for measuring oxygen saturation using pulse oximeter.

Performance of procedure for selected client.

APPLY WARM/COLD APPLICATIONS

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client who requires either warm or cold applications as part of the treatment plan and given the following equipment and materials:

heating pad	appropriate screening
ice bags	compresses, if ordered
paper	moist dressings
pen	cloth cover

WORK TO BE PERFORMED

Follow safe principles of heat or cold applications.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time will vary according to client condition, prescription, institutional protocol and/or type of application.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Demonstrate appropriate precautions when applying heat or cold to the skin. Special attention is given to:
   a. elderly clients,
   b. young children,
   c. clients who are uncooperative and confused,
   d. clients who are not aware of their surroundings,
   e. clients who are paralyzed,
   f. clients with skin damage and/or those with impaired circulation.
2. Instruct client, family member or caregiver about use of a heating pad in the home, including the following:
   a. Heating pads should not be used with moist dressings.
   b. Client's body should not lie on top of the heating pad.
3. Check clients receiving heat treatments frequently, i.e., every 15-30 minutes because sensitivity to heat varies.
4. Wring out compresses to prevent dripping and change every five minutes.
5. Check areas being treated with cold applications every 15-30 minutes for numbness or discoloration.
6. Fill ice bags 1/2 to 2/3 full and cover with cloth such as a terry towel. Rubber or plastic covers should not touch the skin.
7. Report and record use of warm/cold applications according to facility guidelines. Report should include characteristics of skin and client response to application.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for applying warm/cold applications.

Performance of procedure for selected client.

CHANGE NONSTERILE DRESSINGS

(Licensed Practical or *Registered Nurse)*

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with an open wound or skin abrasion and given the following equipment and materials:

- paper
- pen
- clean, nonsterile dressing
- nonsterile gloves
- biohazard bag
- appropriate screening
- sterile saline
- materials to cleanse site of wound

WORK TO BE PERFORMED

Use principles of asepsis in providing wound care to apply a non-sterile dressing while providing privacy for the client.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time will vary according to size and location of wound but should not exceed 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (clean, nonsterile dressing; nonsterile gloves; biohazard bag; and materials to cleanse site of wound), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client.
3. Wash hands. Put on nonsterile gloves or place hand in small plastic bag. Grasp old dressing with covered hand and pull off dressing. Turn covering inside-out over the old dressing.
4. Ensure proper disposal of old dressing following agency protocol. Arrange supplies.
5. Cleanse the wound. Sterile saline is the cleansing agent of choice. Topical antiseptics (e.g., povidone-iodine, hexachlorophene, alcohol or boric acid) may be used on intact skin surrounding the wound but should never be used within the wound or if allergy is noted to any of these products.
6. Allow skin to dry. Prepare clean dressing.
7. Apply clean dressing to wound.
8. Remove any materials used to apply the nonsterile dressing, cleansing any items prior to storage. Discard nonsterile gloves according to facility policy and procedure.

9. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
10. Report and record any significant observations (e.g., wound size, color and drainage).

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for changing a nonsterile dressing.

Performance of procedure for selected client.

MAINTAIN FUNCTION OF SELF-CONTAINED WOUND DRAINAGE APPARATUS

(Licensed Practical or Registered Nurse)

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with a wound drainage apparatus in place and given the following equipment and materials:

disposable gloves
alcohol wipes
sterile wound care materials
appropriate screening
graduated container

WORK TO BE PERFORMED

Maintain function of self-contained wound drainage apparatus.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time will vary according to client condition but should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (gloves, alcohol wipes and sterile wound care materials), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Put on gloves.
5. Free the suction unit and place in a secure position.
6. Release vacuum by removing plug. The device should expand fully.
7. Empty contents into graduated container without contaminating the suction unit. Measure and record amount and empty contents into a sterile container if diagnostic tests are required. Avoid splashing. Wear personal protective equipment if indicated.
8. Cleanse around opening and plug with alcohol wipe or cleansing solution approved by facility protocol. Compress the vacuum container and replace plug while container is compressed. This should re-establish suction.
9. Assure integrity of the system. Vacuum container should not immediately re-expand but should stay compressed with very slow expansion.
10. Reattach container to client's gown, making sure the drainage tubing has no kinks.
11. Cleanse site using sterile wound care process. Evaluate insertion site of drain tubing.
12. Remove and discard gloves. Rinse or discard drainage measuring device.
13. Remove any materials used to maintain function of the wound drainage apparatus, cleansing any items prior to storage. Record amount of drainage on output.

14. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
15. Invite visitors to return to bedside.
16. Report and record significant observations, including information about system integrity, wound and drainage site and color and amount of drainage.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for maintaining function of self-contained wound drainage apparatus.

Performance of procedure for selected client.

CHANGE STERILE DRESSING

(Licensed Practical or Registered Nurse)

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with a wound requiring sterile dressing technique and given the following equipment and materials:

- appropriate forms
- appropriate screening
- two sets of gloves
- biohazard bag
- sterile materials for dressing change
- order for dressing change
- pen
- sterile water
- waterproof bag
- tape
- sterile cleansing materials for the wound
- sterile normal saline to loosen the dressing

WORK TO BE PERFORMED

Follow the nursing process in performing a sterile dressing change.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time required for wound care will depend upon client factors determined through assessment which will include location, size and condition of the wound but should not exceed 20 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (sterile materials for dressing change, sterile cleansing materials for the wound, two sets of gloves and biohazard bag), evaluate the order for dressing change, go to the client's room, knock, introduce self and identify the client by checking the arm bracelet.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Use sterile technique and observe universal precautions during dressing change.
5. Remove the old/soiled dressing:
   a. Put on sterile disposable gloves.
   b. Loosen dressing by removing tape from skin. Use care not to disturb wound closures or any newly formed tissue.
   c. Remove old/soiled dressing. Use sterile water or sterile normal saline to loosen the dressing if needed. Do not moisten "wet to dry" dressings.
   d. Place old/soiled dressings in waterproof bag for disposal.
6. Assess condition/characteristics of the wound: color, skin characteristics, presence of drainage, characteristics of any drainage and security of wound closure.

7. Remove gloves. Establish safe, clean site for sterile dressing supplies.
8. Open sterile supplies and cleansing materials. Prepare receptacle for disposing of soiled materials without contaminating sterile field.
9. Put on gloves using sterile technique.
10. Cleanse the wound using supplies provided and observing the following principles:
    a. Cleanse from top to bottom of wound.
    b. Cleanse from center of wound to periphery of wound.
    c. Use cleansing items for one pass over the wound.
    d. Discard used cleansing items.
    e. Place materials used for cleansing in a moisture-proof bag.
11. Redress wound; apply smaller non-adhering dressing to wound followed by primary dressing designed to collect drainage.
12. Cover entire wound with secondary, larger dressing.
13. Remove gloves. Secure dressing with tape.
14. Remove any materials used to change the sterile dressing. Dispose of soiled/old dressings and materials following facility guidelines.
15. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
16. Invite visitors to return to bedside.
17. Report and record characteristics of the wound, amount and type of drainage and characteristics of skin surrounding the wound.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for changing a sterile dressing.

Performance of procedure for selected client.

CARE FOR AN INTRAVENOUS THERAPY SITE

(Registered Nurse)

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with a peripheral intravenous insertion site and given the following equipment and materials:

pen	tape
appropriate forms	appropriate dressing
gloves	moisture-proof receptacle
cleansing materials	sterile dressing

WORK TO BE PERFORMED

Assess status of the insertion site and change the dressing over the insertion site using principles of asepsis.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time required for peripheral intravenous insertion site care should not exceed 10 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (gloves, cleansing materials and sterile dressing), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to the client, family member or caregiver.
3. Wash hands.
4. Place moisture-proof receptacle in position to receive soiled/old dressing. Put on disposable gloves to remove the old dressing. Remove the old/soiled dressing, taking care not to disturb the insertion site. Discard in proper receptacle. Remove the gloves.
5. Assess peripheral intravenous site by observing for redness, edema and/or feeling of tenderness.
6. Prepare a stable sterile work site. Open packages for cleansing and clean dressing. Put on sterile gloves.
7. Cleanse the intravenous insertion site moving from center to periphery.
8. Ensure that insertion is securely placed and cover with new dressing. Remove gloves and discard.
9. Remove any materials used to provide care for a peripheral intravenous insertion site, cleansing any items prior to storage.
10. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.

11. Invite visitors to return to bedside.
12. Report and record change of dressing and status of peripheral intravenous insertion site.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for caring for an intravenous therapy site.

Performance of procedure for selected client.

IRRIGATE WOUND

(Licensed Practical or Registered Nurse)

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with an open wound and given the following equipment and materials:

solution for irrigation	personal protective equipment
syringe	disposable gloves
catheter	sterile container
emesis basin	biohazard bag
linen protector	disposable moisture-proof receptacle

WORK TO BE PERFORMED

Irrigate wound following principles of wound care and principles of asepsis.

PERFORMANCE CRITERIA

Following completion of wound irrigation, the client will be comfortable.

Time required to irrigate a wound should not exceed 30 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (solution for irrigation ordered by physician, syringe, catheter, emesis basin, linen protector, disposable moisture-proof receptacle and personal protective equipment), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to the client, family member or caregiver.
3. Wash hands.
4. Prepare materials and bring irrigation solution to room temperature.
5. Position client so that irrigation solution will leave wound cavity. Protect bed linen. Place receptacle to receive solution.
6. Place moisture-proof receptacle in position to receive old/soiled dressing. Put on gloves and remove the old/soiled dressing. Dispose of soiled dressing and gloves in biohazard bag per facility policy.
7. Establish sterile field on a stable surface.
8. Pour irrigating solution into sterile container.
9. Put on sterile gloves.
10. Prepare equipment for irrigating wound using syringe with tubing to direct irrigating solution into wound cavity. Position collection basin to receive solution and drainage.
11. Draw irrigating solution into syringe. Insert catheter into wound cavity. Inject solution into wound cavity and allow to drain.
12. Continue irrigating wound until solution is used or drainage returns clear.
13. Clean area around wound and reapply dressings using sterile technique.

14. Remove any materials used to irrigate wound, disposing of drainage in toilet. Dispose of soiled dressing using biohazard bag and following agency protocol.
15. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
16. Invite visitors to return to bedside.
17. Report and record completion of procedure. Make observation about character of drainage and condition of wound.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observation for irrigating a wound.

Performance of procedure for selected client.

REMOVE SUTURES

(Licensed Practical or Registered Nurse)

Perform nursing care based on principles of wound care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client with sutures in place and given the following equipment and materials:

suture removal equipment
materials to cleanse wound
biohazard bag
gloves
sterile dressing tape
appropriate screening
appropriate forms
pen

WORK TO BE PERFORMED

Follow the nursing process and use principles of asepsis in providing wound care and removing sutures.

PERFORMANCE CRITERIA

Skill will be performed with 100% accuracy.

Time required for wound care and removal of sutures will depend upon client factors determined through assessment which will include location, size and condition of the wound. Time should not exceed 15 minutes.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (suture removal equipment, materials to cleanse wound following suture removal, biohazard bag and gloves), go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
3. Wash hands.
4. Understand the type of suture in order to accurately follow removal criteria.
5. Put on gloves. Remove and discard dressing if in place. Remove and discard gloves.
6. Observe wound characteristics.
7. Establish stable, sterile work area for supplies and suture removal equipment.
8. Put on sterile gloves. Clean the wound area and suture line.
9. Follow general principles for suture removal: cut at one end of the exposed suture, remove by pulling hidden portion out. Do not pull exposed portion through subcutaneous tissue.
   Note: Remove every other interrupted suture first, testing for integrity of incision. Then remove remaining sutures.
10. Clean wound and redress as necessary.
11. Remove and discard disposable materials used to remove sutures, cleansing any reusable items prior to storage. Dispose of soiled dressings and materials in biohazard bag following agency protocol.

12. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
13. Invite visitors to return to bedside.
14. Report and record any significant observations.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of physical care and observations for removing sutures.

Performance of procedure for selected client.

DEMONSTRATE PROBLEM SOLVING

(Licensed Practical or Registered Nurse)

Use the nursing process as the expected approach to providing client care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given assigned clients and the following equipment and materials:

pen
appropriate forms for data collection and establishing care plan
any other equipment needed to collect and document data

WORK TO BE PERFORMED

Assist in collecting assessment data, recognizing sociocultural factors that may affect care. Identify common needs and problems. Assist with the formulation of the individualized plan of care and participate in the evaluation of nursing care given.

PERFORMANCE CRITERIA

This behavior will be exhibited 100% of the time.

A time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Understand the scope of practice of Practical Nurse as defined in the Illinois Nursing Act and the Rules for Administration of the Act.
2. Meet the expectations for using nursing process as outlined in the Test Plan for the National Council Licensure Examination for Practical Nurses.
3. Assess: Participate in establishing a data base.
   a. Gather information relative to the client.
   b. Communicate information gained in data collection.
   c. Participate in the formulation of nursing diagnoses.
4. Plan: Participate in setting goals for meeting client's needs and designing strategies to achieve these goals.
   a. Assist in the formulation of goals of care with client.
   b. Assist in the development of a plan of care.
5. Implement: Initiate and complete actions necessary to accomplish the defined goals.
   a. Organize and manage client's care.
   b. Provide care to achieve established goals of care.
   c. Communicate nurse interventions.
6. Evaluate: Participate in determining the extent to which goals have been achieved and interventions have been successful.
   a. Compare actual outcomes with expected outcomes of client care.
   b. Communicate findings.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of problem solving in using nursing process as standard of nurse actions in providing client care.

Completion of case studies as part of classroom exercise, alone and in collaboration with other learners.

Use of nursing process in meeting the clinical management needs of assigned clients in experiential learning.

DEMONSTRATE CRITICAL ANALYSIS

(Registered Nurse)

Use the nursing process as the expected approach to providing client care.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given an assigned client and the following equipment and materials:

documentation
appropriate forms for data collection
appropriate equipment for establishing care plan and communicating the developed plan

WORK TO BE PERFORMED

Analyze data from client, family and other health care resources and select appropriate nursing diagnosis.

PERFORMANCE CRITERIA

Evaluate client's and significant others' status and identify alternative methods of meeting needs, incorporating an understanding of sociocultural factors.

This behavior will be exhibited 100% of the time.

A time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Perform within the scope of practice for RN as defined in the Illinois Nursing Act and the Rules for Administration of the Act.
2. Meet the expectations for using nursing process as outlined in the Test Plan for the National Council Licensure Examination for Registered Nurses.
3. Assess: Establish a database.
   a. Gather objective and subjective information relative to the client.
   b. Confirm data.
   c. Communicate information gained in assessment.
4. Analyze: Identify actual or potential health care needs and/or problems based on assessment.
   a. Interpret data.
   b. Formulate client's nursing diagnoses.
   c. Communicate results of analysis.
5. Plan: Set goals for meeting client's needs and design strategies to achieve these goals.
   a. Prioritize nursing diagnoses.
   b. Determine goals of care.
   c. Formulate outcome criteria for goals of care with client.
   d. Develop plan of care and modify as necessary.
   e. Collaborate with other health care team members when planning delivery of client's care.
   f. Communicate plan of care.

6. Implement: Initiate and complete actions necessary to accomplish the defined goals.
   a. Organize and manage client's care.
   b. Counsel and teach client, significant others and/or health care team members.
   c. Provide care to achieve established goals of care.
   d. Supervise and coordinate the delivery of client's care provided by nursing personnel.
   e. Communicate nursing interventions.
7. Evaluate: Determine the extent to which goals have been achieved and interventions have been successful.
   a. Compare actual outcomes with expected outcomes of care.
   b. Evaluate the client's ability to implement self-care.
   c. Evaluate health care team members' ability to implement client care.
   d. Communicate evaluation findings.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of critical analysis in using nursing process as standard of nurse actions in providing client care.

Completion of case studies as part of classroom exercise, alone and in collaboration with other learners.

Use of nursing process in meeting the clinical management needs of assigned clients in experiential learning.

ADMINISTER MEDICATIONS

(Licensed Practical or Registered Nurse)

Meet standard expectations for safety in administering medication regardless of the route used.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

- complete medicine order
- watch with second hand
- appropriate documentation forms
- pen
- medicine
- syringe
- medicine cup
- alcohol wipes
- drug reference manual

Note: State principles of *safe administration* of *medications.*

WORK TO BE PERFORMED

Administer medications safely to one or more clients with faculty supervision and within educational preparation without violating clients' rights.

PERFORMANCE CRITERIA

Administer all medications to designated group of at least 10 clients over an 8-hour period with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Check accuracy of the medication order. Each order should include the client's full name, the order date, the name of the medication, the dosage, the method and frequency of administration and the signature of the physician ordering the medication. The learner is accountable for administration of the correct drug; therefore, if the learner has reason to question interpretation of an order, the learner should bring it to the attention of the supervising licensed personnel. This should be done prior to administration of the medication.
2. Verbalize knowledge about the drug, any side effects and precautions prior to administration.
3. Follow facility guidelines for administration of controlled substances.
4. Follow any additional facility guidelines for assuring correct medication administration.
5. Verbalize knowledge of the five "rights" (right drug, right dose, right time, right route and right client) of medication administration.
6. Read the label of the drug three times prior to administration to prevent error in preparing medications (when it is secured, when it is prepared for administration and following replacement in the storage compartment).
7. Ensure the drug preparation is appropriate for the route prescribed.
8. Prepare, administer and chart only the medications you have prepared. The person preparing the medication administers the medication and charts the administration.
9. Identify the client correctly and carefully, using appropriate means of identification including the wrist bracelet, the identification notice in the room and by asking the client his/her name or by any other facility protocol required.

10. Respond appropriately to client questions about the drug being administered. Honor the request of a client not to take a drug. Report such circumstance to the supervising licensed personnel and chart the incident.
11. Follow any prescriptive assessment actions prior to drug administration. Report actions taken as result of assessment.
12. Do not leave medications at the bedside unless protocol demands otherwise.
13. Medications should be administered within 30 minutes of time ordered with the exception of pre-operative medications given at exact time ordered and medications given hourly or every two hours.
14. Follow facility guidelines for having two people check accuracy of certain types of medications.
15. Follow facility guidelines for reporting the incident if client vomits following oral administration of medication.
16. Record the administration of the medication including the time, the name of the drug, the dosage, the route of administration and any related information.
17. Notify supervising licensed personnel of intentional omission of any medication including explanation of omission.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of administering medications.

Administer medications to one client.

Administer medications to a designated set of 10 clients over an 8-hour period.

ADMINISTER ORAL MEDICATIONS

IL. 96.HLT/SOC.NU.75

(Licensed Practical or Registered Nurse)

Meet standard expectations for safety in administering medication regardless of the route used.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to clients requiring oral medications and given the following equipment and materials:

medication tray or cart
medication card/computer printout/identification system
disposable medication cups
provisions for privacy of client
appropriate form to chart action plan

Note: State principles of safe administration of oral medications.

WORK TO BE PERFORMED

Administer oral medications safely to one or more client(s) under faculty supervision and within educational preparation without violating clients' rights.

PERFORMANCE CRITERIA

Administer oral medications to designated group of at least 10 clients over an 8-hour period with 100% accuracy.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Check accuracy of the medication order. Each order should include the client's full name, the order date, the name of the medication, the dosage, the method and frequency of administration and the signature of the physician ordering the medication. The learner is accountable for administration of the correct drug; therefore, if the learner has reason to question an interpretation of an order, the learner should bring it to the attention of the supervising licensed personnel. This should be done prior to administration of the medication.
2. Assemble equipment (medication tray or cart, medication card/computer printout/ identification system and disposable medication cups).
3. Compare medication provided with directions given by medication identification/delivery system. Question any discrepancy. Follow facility guidelines for the administration system used in that facility.
4. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
5. Provide for privacy of the client.
6. Wash hands.
7. Follow general guidelines for safe administration of medications.
8. Explain the purpose of the medication and type of medication.
9. Administer the medication. If client needs assistance to swallow medication, assess degree and type of need. Take appropriate action to ensure safe and effective administration of the medication.
10. Administer the medication following any particular instructions with consideration for any special client condition.
11. Stay with client until all medication is taken and swallowed.

12. Ensure that client is in a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand.
13. Follow institutional protocol for recording administration of the medication. Report any unusual findings to supervising licensed personnel and in record.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of administering medications.

Administer oral medications to one client.

Administer oral medications to a designated set of 10 clients over an 8-hour period.

ADMINISTER INTRAMUSCULAR INJECTION

(Licensed Practical or Registered Nurse)

Meet standard expectations for safety in administering medication regardless of the route used.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to clients requiring intramuscular injections and given the following equipment and materials:

medication	appropriate forms
syringes and needles	provisions for privacy
alcohol wipes	container used for needles
disposable gloves	appropriate screening
medication order/computer printout and identification system	gloves

Note: State principles of safe administration of intramuscular medications.

Demonstrate the integration of principles of anatomy and physiology with those of intramuscular injection sites.

Demonstrate universal precautions when administering the intramuscular injection.

WORK TO BE PERFORMED

Administer intramuscular medication meeting standard expectations.

PERFORMANCE CRITERIA

Administer five intramuscular injections with supervision with 100% accuracy.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment.
2. Check accuracy of the medication order. Each order should include the client's full name, the order date, the name of the medication, the dosage, the method and frequency of administration and the signature of the physician ordering the medication. The learner is accountable for administration of the correct drug; therefore, if the learner has reason to question interpretation of an order, the learner should bring it to the attention of the supervising licensed personnel. This should be done prior to administration of the medication.
3. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
4. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
5. Wash hands.
6. Follow guidelines for safe administration of medication, including use of gloves for administration of injections.

7. Choose a site for administering the medication using a reference guide of acceptable sites. Make sure site is not tender, hard or inflamed or does not have other characteristics which would impair injection and absorption. Position the client for best viewing of the site and control of the act of intramuscular administration.
8. Remove needle cover. Remove excess air by inverting barrel and pushing plunger. Bring small bubble (.2) of air into barrel of syringe by pulling back on plunger.
9. Clean skin site of injection with sterile alcohol wipes according to facility guidelines. Put on nonsterile gloves.
10. Spread skin at injection site to make entry easier.
11. Using dominant hand and steady, forceful technique, pierce the skin over the injection site.
12. Pull plunger of syringe back to check for blood entering the barrel unless contraindicated. If blood returns, remove the needle, discard the syringe and medication and prepare new solution.
13. Inject medication in slow, steady fashion, if no blood appears.
14. Withdraw the needle, holding the skin firm with the alcohol sponge.
15. Massage the area lightly with alcohol wipe to facilitate dispersion of medication in muscle if not contraindicated.
16. Dispose of supplies according to institutional protocol and use proper technique to dispose of needles and sharps.
17. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; remove any screening used for privacy; remove any soiled linens; and wash hands.
18. Follow institutional protocol to record the administration of medication. Report additional significant assessment findings to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of administering medications.

Administer five intramuscular injections.

ADMINISTER SUBCUTANEOUS INJECTION

(Licensed Practical or Registered Nurse)

Meet standard expectations for safety in administering medication regardless of the route used.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client requiring subcutaneous injection and given the following equipment and materials:

medication order	nonsterile gloves
syringe	alcohol wipe
appropriate screening	

Note: *State principles of safe administration of subcutaneous injection.*

WORK TO BE PERFORMED

Demonstrate principles of universal precautions when administering subcutaneous injection integrating principles of anatomy and physiology.

PERFORMANCE CRITERIA

Administer three subcutaneous injections with supervision with 100% accuracy.

Time will vary according to client condition.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble necessary equipment.
2. Check accuracy of the medication order. Each order should include the client's full name, the order date, the name of the medication, the dosage, the method and frequency of administration and the signature of the physician ordering the medication. The learner is accountable for administration of the correct drug; therefore, if the learner has reason to question an order, the learner should bring it to the attention of the supervising licensed personnel. This should be done prior to administration of the medication.
3. Wash hands. Prepare solution for administration. Draw the medication into the syringe.
4. Invert the syringe and displace the air from the syringe barrel. Leave a small bubble, 0.2 m., of air to flush medication from needle. Replace needle cover and place syringe with medication in safe place while client is prepared.
5. Go to the client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
6. Provide for privacy of the client. Arrange appropriate screening. Explain procedure to client, family member or caregiver.
7. Wash hands. Put on nonsterile gloves.
8. Follow guidelines for safe administration of medications.
9. Consult reference for acceptable sites and select an appropriate site. Make sure site is not tender, hard or inflamed or does not have other characteristics which would impair injection and absorption.
10. Clean area of injection with alcohol wipe using circular motion and cleaning from middle to periphery.

11. Using the nondominant hand, pinch or spread the skin at the injection site. Insert the needle into the subcutaneous tissue at a 90° or 45° angle. Steady the barrel with the nondominant hand moving the dominant hand to the syringe plunger.
12. Pull back on the plunger to aspirate for blood. If blood returns in the barrel, withdraw the needle and discard the medication. Prepare a new injection. If no blood is returned, inject the medication, holding the syringe steady.
13. Withdraw the needle while holding skin taut with alcohol wipe. Wipe the area with the alcohol wipe. Massage the area to aid with dispersion of the medication if appropriate for the medication.
14. Restore client to comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return bed to lowest position; remove any screening used for privacy; and wash hands.
15. Invite visitors to return to bedside.
16. Follow institutional protocol for recording administration of the medication. Report additional significant assessment findings to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of administering medications.

Administer three subcutaneous injections.

ADMINISTER MEDICATION BY SUPPOSITORY

(Licensed Practical or Registered Nurse)

Meet standard expectations for safety in administering medication regardless of the route used.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client scheduled to receive medication through the rectal suppository route and given the following equipment and materials:

medication in suppository form	medication order
disposable glove	tissues
lubricant	disposable bag

WORK TO BE PERFORMED

Principles of asepsis and safety will be used to administer the rectal suppository while integrating the principles of anatomy and physiology with those of medication therapy.

PERFORMANCE CRITERIA

The learner will administer medication by rectal suppository three times with supervision.

Following administration of the rectal suppository, the client will be returned to a safe and comfortable position.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assemble equipment (medication in suppository form, glove and lubricant), go to client's room, knock, introduce self and identify the client by checking the arm bracelet or using facility-approved and accepted method of identification.
2. Provide for privacy of the client. Arrange appropriate screening. Explain the procedure to the client, family member or caregiver.
3. Wash hands.
4. Help the client assume a left side-lying/lateral position with the top knee in acute flexion.
5. Unwrap the suppository and place it on the work surface on the wrapper or a clean, protected surface. Place a small amount of lubricant on the tip of the suppository.
6. Put on the glove.
7. Ask the client to breathe deeply to help relax the anal sphincter to ease insertion of the suppository. The suppository is inserted in a smooth motion up to 10 cm. (4") into the rectal passage with the finger of the gloved hand directing the suppository into the anus. Attempt to place the suppository along the rectal wall.
8. Remove finger (the glove is removed by drawing the inside over the outside). Wipe lubricant off anus.
9. Encourage the client to hold the buttocks together to prevent expulsion of the suppository in response to an urge to defecate.

10. Restore the client to a comfortable and safe position. Leave signal cord, telephone and fresh water close at hand; return the bed to lowest position; remove any screening used for privacy; remove any soiled linens; and wash hands.
11. Invite visitors to return to bedside.
12. Record medication administration according to institutional protocols. Report significant assessment findings to supervising licensed personnel.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of administering medications.

Administer medication by suppository three times.

USE PRINCIPLES OF COMMUNICATION

Use principles of communication with client, family and staff.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client in a health care setting.

WORK TO BE PERFORMED

Perform as a team member using principles of communication in all interactions with client, family and other members of health care team and maintaining ethical and legal behavior.

PERFORMANCE CRITERIA

This behavior is to be exhibited 100% of the time.

A time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Verbalize factual information about the institution and the care unit to the individual client to enhance client trust in the health care being provided.
2. Use helping and assisting language to gain cooperation and trust through the use of non-threatening, assertive language.
3. Answer call system in health care facility as soon as possible to initiate contact between client and care providers.
4. Use communication to coordinate client care and influence consumer satisfaction.
5. Use active listening techniques when communicating in the health care setting.
6. Integrate multicultural, multilingual needs into a client's plan of care.
7. Adapt communication to address individual needs, including the use of paraphrasing and translating.
8. Use open-ended questions that cannot be answered with "yes" or "no."
9. Listen and clarify what is heard.
10. Put words into situational context provided by the environment, by participants in process and through nonverbal cues.
11. Clarify interpretation of communication.
12. Use nonverbal communication in a positive manner.
13. Clarify nonverbal communication demonstrated by client.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of communication.

Observation of communication between learner and client during performance of assigned responsibilities.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

Equipment necessary will depend upon type of data being transmitted.

Note: Provide response for information sought about clients.

WORK TO BE PERFORMED

Given practice set of client data, necessary data and documentation forms, follow facility guidelines in recording that information according to protocol established for given health care.

PERFORMANCE CRITERIA

Following introduction to the use of communication technology, proper use of the technology in recording client information will be demonstrated 100% of the time.

Time limit will vary according to circumstance and will be set by supervising licensed personnel and agency needs.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Assess use of criteria of facility protocol for communication/information processing.
2. Use facility-specific process for communication.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of methods used for exchange of information.

Document and convey information about assigned client correctly.

COMMUNICATE AND COLLABORATE WITHIN HEALTH CARE TEAM

Use principles of communication with client, family and staff.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

Equipment necessary will depend upon type of communication and collaboration taking place.

WORK TO BE PERFORMED

Assigned to a health care team, participate in a collaborative fashion within their scope of practice to achieve the goals of the health care team.

PERFORMANCE CRITERIA

A time limit is not appropriate for this skill standard.

The learner will reflect communication as an essential ingredient of nursing practice and the purposeful use of communication in relationships 100% of the time.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Identify specific roles and accompanying tasks of members of the health care team.
2. Listen to instructions given for care. Clarify instructions which are not understood. Request assistance and/or supervision when unsure of skill performance required.
3. Identify communication habits and performance which may be a detriment to accomplishing goals assigned to the health care team.
4. Report and record information promptly about condition of client and results of treatments provided to the client.
5. Report and record any part of assignment not accomplished in a timely fashion along with explanation of why assignment was not completed.
6. Accept, request and offer help when required to meet care needs of clients.
7. Display courtesy and a sense of dignity to co-workers, clients and visitors to the facility.
8. Maintain confidentiality about all matters encountered in the work setting.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written assessment of case study situations.

Observation of behavior in the work situation.

ESTABLISH A PLAN OF CARE

(Registered Nurse)

Use principles of communication with client, family and staff.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client and given the following equipment and materials:

- pen
- equipment necessary to assess client
- data collection forms
- proper forms to establish a plan of care for client

WORK TO BE PERFORMED

Work with the client and family to formulate a plan of care utilizing the nursing process.

PERFORMANCE CRITERIA

A diagnostic impression based on the assessment directs the plan of care.

Formulating the plan of care requires varying lengths of time but should meet facility protocol 100% of the time.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Verbalize knowledge of purpose of developing a care plan to organize the health care team's approach to resolution of client diagnoses.
2. Demonstrate planning as a stage of the nursing process. A nursing care plan is developed using data collected through the assessment process. Critical analysis is evident in the nursing diagnoses developed from the assessment process.
3. Develop a nursing care plan from the nursing diagnoses including:
   a. Statements of client diagnoses,
   b. Statements indicating degree of urgency/priority among the nursing diagnoses based on interpretation of area of deficit and value structure,
   c. Measurable outcome statements which address broadly stated and agreed- upon health goals,
   d. Nursing strategies and time lines to achieve outcome measures.
4. Prepare a written document outlining diagnoses, health care goals with measurable outcomes to achieve the goals and care strategies with nursing orders to accomplish goals.
5. Demonstrate ability to evaluate outcome measures to determine effectiveness of care planning effort.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Develop a written plan of care for assigned client.

ASSESS CLIENT'S AND SIGNIFICANT OTHERS' NEED FOR INFORMATION

(Registered Nurse)

Use principles of communication with client, family and staff.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Given the following equipment and materials:

care plan

appropriate forms

WORK TO BE PERFORMED

Recognize a client's characteristics that will influence the teaching approach and explain how the teaching and learning plan addresses the goals developed for a client's plan of care while being sensitive to cultural context that will influence the client's understanding and response to teaching.

PERFORMANCE CRITERIA

A time limit is not appropriate for this skill standard.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Identify the age, developmental stage and cultural aspects of the client.
2. Verbalize knowledge of client's previous experiences with health processes and assess level of knowledge about health goals through communication.
3. Demonstrate understanding of client's ability to actively participate in the teaching and learning process:
   a. Ability to receive and understand information,
   b. Ability to understand language of teacher,
   c. Degree of sensory impairment.
4. Question and give attention to the learning process to verify the level of client interest and motivation to learn.
5. Identify the client's contextual factors which may influence ability to learn:
   a. Job characteristics,
   b. Family responsibilities,
   c. Expenses of care,
   d. Access to equipment,
   e. Physical condition.
6. Outline factors influencing client's readiness to learn:
   a. Degree of anxiety about condition and the learning process,
   b. Level of understanding about current health status and relation to individual health goals,
   c. Contribution to mutual formulation of goals for learning.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written test of principles of teaching and learning.

Develop teaching/learning assessment report as part of care plan for assigned client.

INSTRUCT, EVALUATE AND REINFORCE HEALTH MAINTENANCE TECHNIQUES AND RESOURCES FOR CLIENT AND SIGNIFICANT OTHERS

(Registered Nurse)

Use principles of communication with client, family and staff.

SKILL STANDARD

CONDITIONS OF PERFORMANCE

Assigned to a client having a need for education and given the following equipment and materials:

reference materials
equipment needed to instruct a specific client

WORK TO BE PERFORMED

Develop a teaching plan for an assigned client using facility protocol.

PERFORMANCE CRITERIA

No time limit is assigned to this skill standard. Instruction, evaluation and reinforcement of health maintenance techniques and resources are expectations during the time of client contact.

PERFORMANCE ELEMENTS AND ASSESSMENT CRITERIA

1. Integrate an understanding of learning theory into the teaching/learning plan.
2. View teaching and learning as a collaborative process in communication.
3. Identify the role of teaching and learning in meeting health goals for the individual client.
4. Focus on how information will help the client work toward a maximal health status.
5. Use enabling, coaching and helping behaviors in the teaching/learning process.

The steps of performance have been numbered to show an appropriate sequence of completing the work; however, a different sequence may be used.

ASSESSMENT AND CREDENTIALING APPROACH

Written tests of principles of teaching and learning.

Develop and implement a teaching/learning plan with a client.

Academic Skills
Skills (and related knowledge) contained in the subject areas and disciplines addressed in most national and state educational standards, including English, mathematics, science, etc.

Assessment
A process of measuring performance against a set of standards through examinations, practical tests, performance observations and/or the completion of work portfolios.

Content Standard
A specification of what someone should know or be able to do to successfully perform a work activity or demonstrate a skill.

Critical Work Functions
Distinct and economically meaningful sets of work activities critical to a work process or business unit which are performed to achieve a given work objective with work outputs that have definable performance criteria. A critical work function has three major components:

- **Conditions of Performance:** The information, tools, equipment and other resources provided to a person for a work performance.
- **Work to Be Performed:** A description of the work to be performed.
- **Performance Criteria:** The criteria used to determine the required level of performance. These criteria could include product characteristics (e.g., accuracy levels, appearance), process or procedure requirements (e.g., safety, standard professional procedures) and time and resource requirements. The IOSSCC requires that these performance criteria be further specified by more detailed individual performance elements and assessment criteria.

Credentialing
The provision of a certificate or award to an individual indicating the attainment of a designated set of knowledge and skills and/or the demonstration of a set of critical work functions for an industry/occupational area.

Illinois Occupational Skill Standards and Credentialing Council (IOSSCC)
Legislated body representing business and industry which establishes skill standards criteria, endorses final products approved by the industry subcouncil and standards development committee and assists in marketing and dissemination of occupational skill standards.

Industry
Type of economic activity, or product or service produced or provided in a physical location (employer establishment). They are usually defined in terms of the Standard Industrial Classification (SIC) system.

Industry Subcouncil	Representatives from business/industry and education responsible for identifying and prioritizing occupations for which occupational performance skill standards are adapted, adopted or developed. They establish standards development committees and submit developed skill standards to the IOSSCC for endorsement. They design marketing plans and promote endorsed skill standards across the industry.
Knowledge	Understanding the facts, principles, processes, methods and techniques related to a particular subject area, occupation or industry.
Occupation	A group or cluster of jobs, sharing a common set of work functions and tasks, work products/services and/or worker characteristics. Occupations are generally defined in terms of a national classification system including the Standard Occupational Classification (SOC), Occupational Employment Statistics (OES) and the Dictionary of Occupational Titles (DOT).
Occupational Cluster	Grouping of occupations from one or more industries that share common skill requirements.
Occupational Skill Standards	Specifications of content and performance standards for critical work functions or activities and the underlying academic, workplace and occupational knowledge and skills needed for an occupation or an industry/occupational area.
Occupational Skills	Technical skills (and related knowledge) required to perform the work functions and activities within an occupation.
Performance Standard	A specification of the criteria used to judge the successful performance of a work activity or the demonstration of a skill.
Product Developer	Individual contracted to work with the standard development committee, state liaison, industry subcouncil and IOSSCC for the adaptation, adoption or development of skill standards content.
Reliability	The degree of precision or error in an assessment system so repeated measurements yield consistent results.
Skill	A combination of perceptual, motor, manual, intellectual and social abilities used to perform a work activity.
Skill Standard	Specifies the knowledge and competencies required to perform successfully in the workplace.
Standards Development Committee	Incumbent workers, supervisors and human resource persons within the industry who perform the skills for which standards are being developed. Secondary and postsecondary educators are also represented on the committee. They identify and verify occupational skill standards and assessment mechanisms and recommend products to the industry subcouncil for approval.

State Liaison	Individual responsible for communicating information among all parties (IOSSCC, subcouncil, standard development committee, product developer, project director, etc.) in skill standard development.
Third-Party Assessment	An assessment system in which an industry-designated organization (other than the training provider) administers and controls the assessment process to ensure objectivity and consistency. The training provider could be directly involved in the assessment process under the direction and control of a third-party organization.
Validity	The degree of correspondence between performance in the assessment system and job performance.
Workplace Skills	The generic skills essential to seeking, obtaining, keeping and advancing in any job. These skills are related to the performance of critical work functions across a wide variety of industries and occupations including problem solving, leadership, teamwork, etc.

Margaret Blackshere	AFL-CIO
David Emerson	Downstate National Bank
Michael O'Neill	Chicago Building Trades Council
Janet Payne	United Samaritans Medical Center
Gerald Schmidt	Illinois Manufacturing Association (Retired) Caterpillar, Inc.
Jim Schultz	Illinois Retail Merchants Association Walgreen Company
Larry Vaughn	Illinois Chamber of Commerce

Joseph A. Bonefeste, Ph.D.	Chair, Executive Director Illinois Health Care Cost Containment Council
Jane Clark	Clinical Educator The Glenbrook Hospital
Lucille Davis, R.N., Ph.D.	Dean, College of Nursing & Allied Health Professions Chicago State University
Pia Davis	Vice President, SEIU #73
Edward J. Fesco, M.D.	Physician
Paula Garrott, Ed.M., MT (ASCP), CLS (NCA)	Associate Professor and Director Clinical Laboratory Science Program University of Illinois at Springfield
Rose Hall	Belleville Area College
Nancy Krier	Illinois Hospital Association
Cheryl Lowney	Senior Vice-President, Nursing Services Heritage Enterprises
Jan Matuska, R.N.	Curriculum Coordinator Pekin High School
Sharon McClellan, M.S., R.N.C.	Medical Center Educator Veterans Administration Medical Center
Sue Ellen Meister	Representative of the Illinois Nurse Association
Peter Paulson, D.D.S.	Secretary, Illinois State Dental Society
Creighton J. Petkovich	United Samaritans Medical Center
Jane B. Pond, L.P.N.	President, Licensed Practical Nurses Association of Illinois
Kevin Smith, M.D.	Medical Director, Dreyer Clinic
Carol Snetcher	Nurse Administrator Freeport Memorial Home Health Care

Gloria Tarvin	Chairperson of Allied Health/Nursing Rehabilitative Institute of Chicago
Dr. Walter Zinn	Optometrist
Kathryn Torricelli	State Liaison Illinois State Board of Education

NURSING CLUSTER STANDARDS DEVELOPMENT COMMITTEE

Reita Beck, C.N.A	Freeport Memorial Home Health Care
Nicole Boose, M.S.N.	Clinical Coordinator United Samaritans Medical Center
Paula Gathard, R.N.	Division of Mental Health Department of Mental Health and Developmental Disabilities
Eloise Geiselhofer, L.P.N.	Evergreen Park
Rhowena Genandt, C.N.A.	Freeport Memorial Home Health Care
Louvenia Hill, L.P.N.	Chicago
Vicky Hosey, R.N.	Illinois Department of Public Health Education and Training
Jan Matuska, R.N.	Pekin Tech-Ed Center
Barbara Nadziejko, R.N.	Fairview Heights
Diane Pavesic, L.P.N.	Rockford
Ingrid Schoenberg, R.N.	Nursing Supervisor Singer Mental Health and Developmental Disabilities Center
Anne Williams, M.S.N., C.N.S.	John A. Logan College
Mary Zukowski, R.N.	Nursing Supervisor Chicago Read Mental Health Center
Mary Mulcahy, R.N., Ed.D.	Product Developer University of Illinois-Springfield
Kathryn Torricelli	State Liaison Illinois State Board of Education

I. Occupational Definition and Justification

A. Occupational Definitions

The Health and Social Services Subcouncil chose to begin performance skill standard development with the Nursing Services Cluster. This cluster is comprised of the three occupations of Registered Nurse, Licensed Practical Nurse and Certified Nurse Assistant. Definitions for each of the three occupations are provided below.

1. **Registered Nurse (RN)** is an individual who supervises, teaches and delegates nursing care to members of the health care team and delivers direct nursing care and treatment to clients in a variety of facilities and settings. Clients and families may be at any stage along the wellness/illness continuum. RNs counsel and educate clients and families about their illnesses, preventative health measures and self-care responsibilities. Responsibilities include administering medications and treatments as prescribed by a licensed physician, dentist or podiatrist; performing skilled technical procedures; and providing personal nursing care. Registered nurses provide education to health care team members, clients and significant others. Evaluation, assessment, determination and implementation of a nursing plan of care are responsibilities of the RN. Individuals are required to attend an approved program for two years (Associate Degree Nurse-ADN), three years (Diploma Nurse-RN), or four years (Baccalaureate Nurse-BSN). All three programs of instruction require the learner to successfully pass a written licensing exam (NCLEX RN).

2. **Licensed Practical Nurse (LPN)** is an individual who delivers direct nursing care to clients in a variety of facilities and settings. Clients may be at any stage along the wellness/illness continuum. Responsibilities include administering medications and treatments as prescribed by a licensed physician, dentist or podiatrist and performing skilled technical procedures, as well as providing basic nursing care and personal care. Responsibilities include assisting the RN in evaluation, assessment, determination and implementation of a nursing plan of care dependent upon the employer and the LPN's competency, education and experience. LPNs work under the supervision of registered nurses, physicians, dentists or podiatrists. Individuals are required to complete a one-year approved program of instruction and pass a licensing exam (NCLEX PN).

3. **Certified Nurse Assistant (CNA)** is an individual who provides nursing or personal care to clients in a variety of settings under the supervision of a licensed practical nurse or registered nurse. Individuals are required to attend an approved program of instruction and successfully pass a performance skill test of the legislated, prescribed skills and a written exam. Individuals must also qualify for employment by fulfilling all requirements of the criminal background check (SB 358).

B. Employment and Earnings Opportunities

While the earnings potential for CNA does not meet the earnings criteria established by the Illinois Occupational Skill Standards and Credentialing Council (IOSSCC), the skills associated with the occupation are necessary skills and foundations to the higher wage-earning occupations of RN and LPN. In addition, access to the instruction and entry into the occupations of RN and LPN are facilitated through the fulfillment of CNA requirements.

1. **Employment Potential (Nursing Career Path)**

   a. **Certified Nursing Assistants:** The employment growth rate and demand for nursing assistants is expected to be excellent. Much of the expected growth can be attributed to the expansion of long-term care facilities and programs to meet the needs of the nation's increasing elderly population. Additional opportunities may arise as more duties are delegated to nursing assistants. However, the number of persons acquiring certification continues to increase, along with those re-entering the workforce after brief absences. Persons seeking employment in this field in certain areas of the state may find competition for some job openings.

   b. **Licensed Practical Nurses:** Employment of licensed practical nurses is expected to grow much faster than average. The expansion of alternative services such as walk-in centers and clinics will greatly affect the number of LPNs hired. Many people are completing training programs each year in the state. Job prospects should be good, especially in long-term care facilities, home health agencies and private-duty nursing. Opportunities may, however, be more competitive in some local areas.

   c. **Registered Nurses:** Slight shortages may exist in some rural areas, large urban hospitals and some specialty fields. Prospects for entry-level positions remain good, especially for those willing to work evening and night shifts. However, for the first time in many years, some local areas in the state are experiencing slight surpluses.

2. **Earnings Potential**

   a. Beginning wages for nursing assistants range from minimum wage up to $6.00/hour. The national average salary for nursing assistants in 1993 was $7.00/hour. According to the 1994 Occupational Wage Survey for Illinois, average salaries for nursing assistants ranged from $4.50 - $7.00/hour.

   b. According to the 1994 Occupational Wage Survey for Illinois, LPNs working in hospitals earned an average salary of $10.30/hour. LPNs working in doctor's offices earned about $9.20/hour. Starting wage in Illinois is around $8.00/hour. A national survey conducted by the Bureau of Labor Statistics in 1993 reports licensed practical nurses earning an average salary of about $10.90/hour.

   c. Staff nurses earn an average salary of $18.58/hour, according to the 1994 Biennial Survey of Illinois Registered Nurses. The survey reports the lowest-paying nursing position is office nurse at $15.34/hour and the highest is nurse anesthetist at $31.94/ hour. According to a 1993 national survey, registered nurses earned an average salary of $17.20/hour.

C. Career Opportunities and Education and Training Requirements

The occupations possess technical, workplace and related academic skills. The identification of academic skills in relation to the skill standards will be identified utilizing the Illinois Learning Standards where possible.

II. Occupational Standards and Credentials

A. Occupational Standards

B. Assessment and Credentialing System

The following assessment and licensure exams are currently required for these three occupations (Certified Nurse Assistant, Licensed Practical Nurse and Registered Nurse). The CNA exam is regulated by the Illinois Department of Public Health and consists of a performance skill assessment of the legislated performance skills and a written exam administered through Southern Illinois University - Carbondale. A program consisting of both clinical and classroom instruction must be completed. The current LPN and RN NCLEX exams consist of written licensing exams only. Graduation from an approved program of not less than one year for an LPN and two years for an RN is required.

The subcouncil will review and consider all alternatives for assessing the performance skill standards presented. The need for additional credentialing or certification will be reviewed with strong consideration being given to embedding the assessment in the instruction provided at the clinical site. The assessment will be valid and reliable.

III. Industry Support and Commitment

A. Industry Commitment for Development and Updating

1. These performance skill standards were developed by the subcouncil and the standards development committee. The development effort utilized the following steps:

   a. Identification of performance skills.
   b. Review of resources.
   c. Convening of standards development committee.
   d. Validation and approval of performance skills by standards development committee.
   e. Development of draft performance skills.
   f. Review of skill standards by standards development committee.
   g. Review and approval of the skill standards by the subcouncil and practitioners.
   h. Approval of skill standards by the subcouncil.

2. A list of subcouncil and standards development committee members may be seen in Appendixes C and D, respectively.

B. Industry Commitment for Marketing

The Health and Social Services Subcouncil is committed to marketing and obtaining support and endorsement from the leading industry associations impacted by the skill standards. Upon recognition/endorsement of the skill standards by the IOSSCC, the subcouncil strongly recommends developing and providing an inservice/seminar package for members of the Health and Social Services Subcouncil to provide awareness and obtain full industry commitment to the development of a full industry marketing plan.

The subcouncil encourages the availability of occupational skill standards to the public including learners, parents, workers, educators at all levels, employers and industry organizations.

A. Developing an Employment Plan	1. Match interests to employment area. 2. Match aptitudes to employment area. 3. Identify short-term work goals. 4. Match attitudes to job area. 5. Match personality type to job area. 6. Match physical capabilities to job area. 7. Identify career information from counseling sources. 8. Demonstrate a drug-free status.
B. Seeking and Applying for Employment Opportunities	1. Locate employment opportunities. 2. Identify job requirements. 3. Locate resources for finding employment. 4. Prepare a resume. 5. Prepare for job interview. 6. Identify conditions for employment. 7. Evaluate job opportunities. 8. Identify steps in applying for a job. 9. Write job application letter. 10. Write interview follow-up letter. 11. Complete job application form. 12. Identify attire for job interview.
C. Accepting Employment	1. Apply for social security number. 2. Complete state and federal tax forms. 3. Accept or reject employment offer. 4. Complete employee's Withholding Allowance Certificate Form W-4.
D. Communicating on the Job	1. Communicate orally with others. 2. Use telephone etiquette. 3. Interpret the use of body language. 4. Prepare written communication. 5. Follow written directions. 6. Ask questions about tasks.
E. Interpreting the Economics of Work	1. Identify the role of business in the economic system. 2. Describe responsibilities of employee. 3. Describe responsibilities of employer or management. 4. Investigate opportunities and options for business ownership. 5. Assess entrepreneurship skills.
F. Maintaining Professionalism	1. Participate in employment orientation. 2. Assess business image, products and/or services. 3. Identify positive behavior. 4. Identify company dress and appearance standards. 5. Participate in meetings in a positive and constructive manner. 6. Identify work-related terminology. 7. Identify how to treat people with respect.

G. Adapting to and Coping with Change

1. Identify elements of job transition.
2. Formulate transition plan.
3. Identify implementation procedures for a transition plan.
4. Evaluate the transition plan.
5. Exhibit ability to handle stress.
6. Recognize need to change or quit a job.
7. Write a letter of resignation.

H. Solving Problems and Critical Thinking

1. Identify the problem.
2. Clarify purposes and goals.
3. Identify solutions to a problem and their impact.
4. Employ reasoning skills.
5. Evaluate options.
6. Set priorities.
7. Select and implement a solution to a problem.
8. Evaluate results of implemented option.
9. Organize workloads.
10. Assess employer and employee responsibility in solving a problem.

I. Maintaining a Safe and Healthy Work Environment

1. Identify safety and health rules/procedures.
2. Demonstrate the knowledge of equipment in the workplace.
3. Identify conservation and environmental practices and policies.
4. Act during emergencies.
5. Maintain work area.
6. Identify hazardous substances in the workplace.

J. Demonstrating Work Ethics and Behavior

1. Identify established rules, regulations and policies.
2. Practice cost effectiveness.
3. Practice time management.
4. Assume responsibility for decisions and actions.
5. Exhibit pride.
6. Display initiative.
7. Display assertiveness.
8. Demonstrate a willingness to learn.
9. Identify the value of maintaining regular attendance.
10. Apply ethical reasoning.

K. Demonstrating Technological Literacy

1. Demonstrate basic keyboarding skills.
2. Demonstrate basic knowledge of computing.
3. Recognize impact of technological changes on tasks and people.

L. Maintaining Interpersonal Relationships

1. Value individual diversity.
2. Respond to praise or criticism.
3. Provide constructive praise or criticism.
4. Channel and control emotional reactions.
5. Resolve conflicts.
6. Display a positive attitude.
7. Identify and react to sexual intimidation/harassment.

M. Demonstrating Teamwork

1. Identify style of leadership used in teamwork.
2. Match team member skills and group activity.
3. Work with team members.
4. Complete a team task.
5. Evaluate outcomes.

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